Waitemata
District Health Board
Best Care for Everyone

2013/14 to 2015/16

Statement of Intent

2013/14-2015/16 STATEMENT OF INTENT DATED THIS 30 DAY OF June 2013

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 2013/14 by Waitemata DHB and contains non-financial and financial forecast information for 2014/15 and 2015/16 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

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

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MODULE 1: Introduction

Foreword from our Chair and Chief Executive

In healthcare, we enjoy a special privilege rare in most sectors – that of being entrusted with the care of people. At Waitemata DHB, this is something we strive to keep foremost in our minds as we go about the day-to-day duties of caring for the sick and frail, and promoting health in our communities.

Fundamentally we aim to do our best for our population. Our organisational values and promise statement, Best Care for Everyone, reflects this. The values serve to inspire us to always be the best we can be – to strive to provide the best care possible to each and every person, and their family, who walks through our doors.

Looking back, the last two years have seen tremendous growth for our DHB, with the largest expansion of our facilities and services since our organisation first came into existence. An enormous amount of change has occurred and our staff have worked incredibly hard to meet the ever increasing needs of our growing population.

A number of significant milestones have been achieved. These include:

- The 25 bed state-of-the-art Lakeview Cardiology Centre housing a coronary care unit, a step-down unit, a cardiology ward and two cardiac catheterisation laboratories
- The full commissioning of the 50 bed Assessment & Diagnostic Unit, completing the final component of new emergency care facilities at North Shore Hospital
- The commissioning of a new CT scanner at North Shore Hospital. As the first CT scanner of its type in New Zealand, North Shore Hospital is acting as a reference site for other DHBs around the country
- Expansion of the Rangatira paediatric unit at Waitakere Hospital, with ten additional beds, a new indoor playroom, an outdoor garden area, parent kitchen and negative pressure isolation room for children with infectious diseases
- The opening of four new school dental clinics as part of our facilities modernisation programme for child oral health
- New Awhina Health Campus facilities at Waitakere Hospital in joint association with Unitec, providing greatly enhanced opportunities for learning, innovation and collaboration for staff and students in west Auckland.

In February 2012, we also started construction of the Elective Surgery Centre building on the North Shore Hospital site. The $39 million project's aspiration is for a highly efficient and cost effective centre for fast stream elective surgical services – one that would be New Zealand's most productive, with results better than that achieved in both private and other public hospitals in the country. Nearly 6000 operations across a range of specialties are expected to be performed annually once the centre opens in July 2013.

Along with this growth, we have also excelled in our overall performance, ending 2012 having achieved or exceeded five of the six national health targets – one of only four DHBs in New Zealand (and the only large DHB) to do so. Waitemata is also a national leader in the health outcomes achieved for its population with increased life expectancy, the lowest cancer and cardiovascular disease mortality, low levels of smoking and also diabetes prevalence.

We've also added new services for our population, including:

- A gestational diabetes service providing assessment and support for women without previously diagnosed diabetes who develop the condition during pregnancy.
- A Long Term Oxygen Therapy service providing assessment, education and support for adults and children who require oxygen support in their own homes

- An interventional radiology service providing minimally-invasive image-guided procedures to diagnose and treat diseases.

Looking forward we look to deliver:

- increased levels of elective surgery with the opening of the Elective Surgery Centre
- more integrated services through further development with primary care
- additional diagnostic capacity including an endoscopy room and MRI
- additional services through our new community dialysis unit.

These achievements and our future plans are a direct result of the dedication and hard work of the countless people who work for our DHB or for our partner organisations in health. An organisation is always only as a good as its people, and we are fortunate to have so many talented and devoted people on staff.

Dr Lester Levy
Chair

Dr Dale Bramley
Chief Executive Officer

Te Tiriti o Waitangi Statement

Waitemata DHB recognises and respects the Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides a 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.

Te Tiriti o Waitangi serves as a conceptual and consistent framework for Māori health gain across the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for the Waitemata DHB can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with manawhenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

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

Guiding Principles

It is proposed that the following nine principles underpin the Waitemata DHB work streams and approaches and provide practical direction for the identification of Māori health priority areas and associated activities and indicators.

Health partnership with manawhenua

This principle is reflected in the memoranda between Waitemata DHB and Te Runanga o Ngati Whatua, which outlines the partnership approach to working together at both governance and operational levels. These memoranda arrangements establish a treaty based health partnership enabling joint collaboration between the Crown and Ngati Whatua in key areas such as funding and planning. To this extent the relationship is designed to ensure the provision of effective health and disability services for Māori resident within the Ngati Whatua tribal rohe (area).

Commitment to Māori communities

This is reflected in the memoranda between Waitemata DHB and Te Whānau o Waipareira Trust. This arrangement enables joint collaboration in key areas of planning and funding and is designed to ensure provision of effective health and disability services for Māori.

Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing during their interaction with health services. The approach is whānau-centred and involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective.

Health equity

As a principle, health equity is concerned with eliminating avoidable, unfair and unjust systematic disparities in health between Māori and non-Māori. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key contribution towards achieving health equity.

Self-determination

This principle is concerned with the right of Māori patients/individuals and collectives to be informed and exert control over their health. This is consistent with full involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence.

Indigeneity

Indigeneity is concerned with the status and rights of Māori as indigenous peoples. The value placed on Indigeneity should be reflected in health policies and programmes that support the retention of Māori identity, the participation of Māori in decision-making, and health development based on the aspirations of Māori.

Ngā kaupapa tuku iho

As a principle, ngā kaupapa tuku iho requires acknowledgment and respect for distinctly Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning, quality programming and service delivery for Māori.

Whole-of-system responsibility

Achieving best health outcomes for whānau and health equity for Māori is a whole-of-system responsibility. Therefore, contributing to Māori health gain and reducing ethnic inequalities in health between Māori and non-Māori is an expectation of all health activities through the whole of the health system.

Evidence-based approaches

The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgment, drawing on a Māori development perspective and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of Māori health policy, purchasing, service delivery and practice.

Context

Who are we and what do we do?

Waitemata DHB was established under the New Zealand Public Health and Disability Act (2000) to:

- improve, promote, and protect the health of communities
- reduce inequalities in health status
- integrate health services, especially primary and secondary care services
- promote effective care or support of those in need of personal health services or disability support

for the 563,000 people of the Waitemata district. Our district encompasses Auckland North and Auckland West.

Our population continues to grow rapidly with migration of people to the Auckland region. We are implementing strategies to improve the efficiency, reach and effectiveness of our services, with our partners in primary care, non-government organisations and our neighbouring DHBs.

Waitemata DHB has been on an upward trajectory for the last three years. Our performance against health targets has resulted in the achievement of five of the six health targets, one of four DHBs to have done this (and the only large DHB). We have added new services including the national Bowel Screening Pilot, gestational diabetes service, long term oxygen therapy service and interventional radiology. We have also built new facilities including the Elective Surgery Centre (opening July 2013), community dental health clinics, Rangatira ward at Waitakere Hospital, interventional radiology suite and intensive care beds for older adults.

In 2013/14 we will continue to focus on providing Best Care for Everyone by embedding the gains already made and implementing new models of care.

Snapshot of Waitemata DHB

- Largest and second fastest growing population of all districts – over 563,000 people, with the population expected to grow by an additional 119,000 people over the next 15 years
- We have the highest proportion of least deprived (deciles one and two) people and the second lowest proportion of highly deprived (decile 10) people of any DHB.
- People who live in our district have the highest life expectancy in New Zealand. We also have the highest life expectancy for Māori in the North Island.
- 18% of our Waitemata population is Asian, 10% Māori and 10% Pacific
- 21% of the population are under 15 years of age, 13% of the population are over 65 years, with around 2% over 85 years old
- 7,900 babies were born to Waitemata residents in 2012
- There were 130,566 publicly funded hospital discharges for Waitemata residents in 2012

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

Nature and scope of activities

We have four key roles which assist us achieve our objectives:

- Planner - DHB planning begins with the assessment of population health need. Health needs assessment, along with input from our key stakeholders (including our community), establishes the important areas of focus within our district and these are balanced alongside national and regional priorities. These inform the Northern Region Health Plan, which sets the longer term priorities for DHBs in the northern region (Northland, Waitemata, Counties-Manukau and Auckland DHBs) as well as the annual plan, statement of intent and Māori Health Plan.
- Funder - Our funding responsibilities cover the totality of services delivered for our population and include a responsibility to provide value for money and to live within our means. These services include those which are hospital based provided at North Shore Hospital and Waitakere Hospital, and community based (ie primary care, aged residential care, home based support services, community pharmacy services, community mental health service, and district nursing).
- Provider - Waitemata DHB provides predominantly secondary hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 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. From 1 July 2013 we will manage the national Hyperbaric Medical Service. 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.
- Owner of crown assets - As an owner of Crown assets, we must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We are responsible for ensuring strong governance and accountability, risk management, audit, and performance monitoring and reporting.

We have an established governance structure, based on the requirements of the New Zealand Public Health and Disability Act, through which the DHB functions. Governance for the 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 to meet its responsibilities, and the meetings of these committees are open to the public.

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

Other interests

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

Three Harbours Health Foundation: Waitemata DHB is the appointer of trustees to this registered charitable trust which holds donations, grants and research funds. The funds are made available for purposes consistent with the wishes of the persons or organisations that provided the funds and with the purposes of the Three Harbours Health Foundation trust deed. These purposes include: provision of comforts and amenities, provision of clinical equipment, funding of training and education, and the funding of clinical trials and research. The priorities for major fund raising for the 2012-2014 period are to strengthen research and innovation within the DHB and its contracted service delivery network.

Waitemata DHB is a shareholder in a number of Crown entity subsidiaries namely Northern Region Alliance Limited, Northern Regional Training Hub Limited, New Zealand Health Innovation Hub Management Limited, and healthAlliance New Zealand Limited.

The Northern Regional Alliance Limited (NRA) is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in three equal shares by Waitemata, Auckland, and Counties Manukau District Health Boards.

NRA has applied for exemption from producing a Statement of Intent (SOI) for the 2013/14 year as a restructuring process is under way and key outputs and budgets are not able to be set until the new structure is in place. NRA will produce a Business Plan including budgets and key outputs for 2013/14 and will report internally and to shareholding DHBs against that business plan commencing with a report in October 2013 for the first quarter of 2013/14. The NRA Annual Report for 2013/14 will report actual results against the Business Plan in a similar manner to that which the two amalgamated companies reported against their annual Statements of Intent. The shareholding DHBs will monitor NRA performance against its Business Plan on a quarterly basis during 2013/14.

Waitemata DHB will seek approval from the Minister of Health to progress any plans to acquire shares or interests in any other company, trusts and/or partnerships.

Factors Affecting our Performance

Across the Auckland region there are similar kinds of challenges:

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

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

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

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

Key areas of risk and opportunity

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

MODULE 2: Strategic Direction

Our wider work programme on culture and values has clearly defined our organisation's purpose as being:

- to promote wellness
- to cure, ameliorate and prevent ill health
- to relieve suffering of those entrusted into our care.

Our focus on Best Care for Everyone means we strive to offer the best care we can to every person and their family receiving our services.

The Board's current local priorities are to embed the substantial gains already made and to implement new models of care to ensure a sustainable future.

Embedding the Gains

- Being clear who we are, what we do and how we do it
- Demonstrating delivery
- Ensuring a solid financial foundation
- Working with Partners to deliver

New Models of Care

- Closer working across the health system
- Empowering patients
- Targeting interventions to deliver real improvements for Māori
- Increasing accessibility to care
- Improving the effectiveness of services

These priorities are based on our current performance and areas for further improvement, and fit with those priorities in the Northern Region Health Service Plan and align with the Māori Health Plan. They also focus us on the streams of work that meet our statutory and government policy responsibilities.

Being clear who we are, what we do and how we do it

The organisation, together with its staff, recently reviewed its values, promise and purpose.

These became the anchor for all we do within the organisation.

Strategic Context

National

The health sector contributes to government priorities by working towards the Ministry of Health's overarching outcomes:

- New Zealanders living longer, healthier and more independent lives
- The health system is cost-effective and supports a productive economy.

These are supported by three high level outcomes, and the other government priorities signalled through the Minister's letter of expectations (refer planning framework diagram). For 2013/14 the government continues to expect Better, Sooner, More Convenient healthcare services for patients and communities within constrained funding increases.

DHBs are expected to engage and invest in three of the Better Public Sector key result areas, increased immunisation rates, reduced rheumatic fever rates and reduced number of childhood assaults (white paper on vulnerable children). DHBs are also expected to achieve the national health targets.

A stronger focus on service integration with primary care is expected, particularly for the management of long term conditions, mental health and health of older peoples (home care, stroke and dementia care) services, and including integrated family health centres, direct referral to diagnostics, clinical pathway development and sharing patient controlled health records.

Faster implementation of the Northern Region Health Plan is expected, including plans for workforce, information technology and capital. Acceleration by DHBs of the work with national health sector agencies – Health Benefits Limited, Health Workforce NZ and Health Quality and Safety Commission – is also expected. Strong clinical leadership and engagement remains essential to achieving the clinical and financial gains sought.

Living within our means continues to be a focus as the government is determined to return to surplus in 2014/15. Productivity gains and further savings initiatives are required to ensure we keep to our budget. Similarly the capital available to the sector is limited; therefore DHBs are expected to rigorously prioritise capital expenditure and fund from internal sources.

DHBs are also expected to deliver on Budget 2013 initiatives and support the national services and national service improvement programmes. The appropriate planning, funding, contracting and monitoring model will be implemented for each National Service, and effective as of 1 July 2013 national services have been identified as: Intestinal Failure, Renal Transplantation and Hyperbaric Medical Service. The latter is to be managed by Waitemata DHB. During 2013/14 a national service improvement programme is being run around services relating to complex epilepsy.

Regional

The Northern Region Health Plan or regional services plan (RSP) has been developed by the four Northern Region DHBs to provide an overall framework for future planning and states the region's priorities. Emphasis has been placed on building on the Better, Sooner, More Convenient platform. This ensures there is good integration across all care settings in the initiatives and directions outlined in the plan. Through our application of strong clinical leadership and the adoption of a whole of system approach, we have identified priority areas to address sustainability (clinical and financial) and inequalities. We plan regionally to ensure a coordinated approach to the development of new services and attempt to ensure that all our respective populations enjoy a similar high quality of service. We have defined tangible benefits against which we will assess our performance. (refer http://www.NDSA.co.nz/FormsDocuments.aspx)

Sub-regional

Auckland and Waitemata DHBs work closely together, and where there is mutual benefit on joint activities. Regionalisation through collaboration is a strategic priority for both Boards who, combined, provide health services to over one million Aucklanders.

The two DHBs share a Board Chair and have Community and Public Health, Disability Support and Māori Health (Manawa Ora) advisory committees that meet jointly. The merger of the primary care Planning and Funding Teams has already increased consistency of relationships and primary care management across the two DHBs. Māori health across the two DHBs is merged as are Pacific health teams. More work areas will be joined during 2013/14, where we know that collaboration will improve health outcomes and improve service delivery. In some cases collaboration will also achieve better economies of scale.

Local

In recent years we have seen the largest expansion of facilities and services at Waitemata since the DHB was established. We have opened new emergency department facilities at Waitakere and North Shore Hospitals, a cardiology centre and assessment and diagnostic unit at North Shore, Awhina health campus facilities, school dental clinics in our communities as well as expansion of paediatric services at Waitakere and new car parking facilities at both sites. Service expansions include renal services, national bowel screening pilot and long term oxygen.

We have also seen a significant improvement in our performance against the national health targets achieving the best overall results of the larger DHBs. We have moved from last place to the first of the large DHBs in the country for shorter waits in the emergency department, and have continuously maintained immunisation coverage rates for our children, elective surgery discharges and better help for smokers to quit. None of this would be possible without our dedicated staff and the support of the primary care sector.

We have placed increasing emphasis on quality including improving the patient experience, improving medication safety, decreasing hospital falls, pressure injuries, infection and readmission rates. Our focus on Best Care For Everyone means we continually strive to create a culture of consistent, high quality care to each and every patient and their family who enters our services.

Clinical leadership is at the core of all we do. We are implementing our enhanced care management and clinical leadership model in chosen services over the year. This will involve clinical leaders taking on the accountability for clinical and financial outcomes for their services.

Moving forward we will continue to see increased demand on our services due to population growth, an aging population and growing prevalence of people with long term conditions eg diabetes and cardiovascular disease. Patient and family expectations for service quality and outcomes along with increased expectations of value by both the government and our community are also increasing. Our Board has considered these challenges and opportunities in confirming our local priorities to consolidate and embed the substantial gains already made and to implement new models of care to ensure we achieve the best possible outcomes across the whole system within the resources available to our DHB.

The following planning framework for Waitemata DHB summarises the key national, regional and local priorities that inform the 2013/14 annual plan and statement of intent, including the key measures we monitor to ensure we are achieving our objectives.

Waitemata DHB Planning Framework

Government priorities	Better, sooner, more convenient health services	Service integration	Regional collaboration	Value for money
MOH's High Level Outcome objectives	Health services are clinically integrated, more convenient & people-centred	New Zealanders are healthier and more independent	Future sustainability of health system is assured	

National priorities	**Six health targets**						
	Emergency Departments	Elective surgery	Faster Cancer treatment	Immunisation	Help to quit smoking	More heart and diabetes checks	
	Other government priorities						
	Reduce rheumatic fever	Clinical integration	Access to diagnostics	Whānau Ora	Mental Health service development plan	PM's youth mental health project	Vulnerable children	Living within our means

Region's goals	Vision: 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		
	Population Health Adding to &increasing the productive life of people in the northern region	Patient Experience Aiming for zero patient harm and performance improvement	Cost/Productivity Region's health resources efficiently & sustainably managed to meet present & future health needs

WDHB Promise Statement (and outcomes monitored)	Best Care for Everyone • Increase life expectancy • Decrease ethnic inequalities in life expectancy
WDHB purpose (and outcomes monitored)	To promote wellness • Healthy lifestyle factors • Well children / Tamariki ora • Youth mental health
	To prevent, ameliorate and cure ill health • Prevalence of diabetes and cardiovascular disease • Vaccine preventable childhood disease incidence • Cancer mortality • Access to elective surgery • Access to appropriate acute care • Overall hospital mortality • Mental health • Smoking prevalence • Infant mortality • Health of older people
	To relieve suffering of those entrusted to our care • Improved patient experience • Quality and safety of services • Reduced waiting times

WDHB Board priorities Priority Populations & Services	Embedding the Gains			New Models of Care		
	Child and Maternal Health	Youth Health	Health of Older People	Māori Health	Pacific Health	Asian, Migrants and Refugees

Output Classes	**Prevention** • Health Protection • Health Promotion • Health Policy/Legislation Advocacy and Advice • Population Based Screening	**Early Detection and Management** • Community referred Testing & Diagnostics • Oral Health • Primary Health Care • Pharmacy	**Intensive Assessment and Treatment** • Acute Services • Maternity • Elective (Inpatient/ Outpatient) • Assessment, Treatment & Rehabilitation (Inpatient) • Mental Health	**Rehabilitation and Support** • Home Based Support • Palliative Care • Residential Care • Mental Health
Enablers	**Workforce**	**Information Communication Technology**	**Facilities**	
	Financial resources			

How will we know we've achieved the outcomes sought?

To enable our DHB to ensure it is achieving the best possible outcomes across the whole system for our community we need to monitor performance of key measures and indicators. Our outcomes performance framework this year and moving forward is based on the three key themes that comprise our purpose statement:

- To promote wellness
- To prevent, ameliorate and cure ill health
- To relieve suffering of those entrusted to our care.

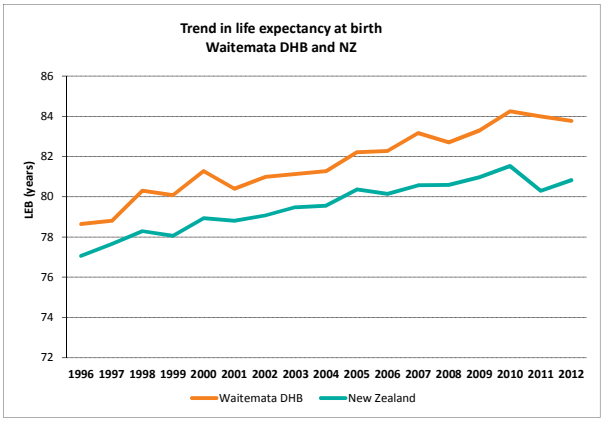
Our goal is to maximise the attainment of this purpose and the health outcomes for our community and in doing so services need to be of the highest quality and safety attainable.

In prior years we have used the three goals of the Northern Regional Health Plan; population health, patient experience and cost/productivity which are aligned with the World Health Organisation policy guidance for health system performance measurement and improvement. Recent work with Professor Richard Bohmer has resulted in a purpose statement linked to the Northern Regional Health Plan goals, but articulated in a way which is much more connected with our organisation and which engages us all in a meaningful way to remind us of the purpose for which our services are undertaken and for the population we serve.

We will be developing metrics, targets and a reporting process to support the purpose statement and the enhanced clinical management model. The metrics will include process measures and functional status as well as immediate, intermediate and long term outcome measures. The measures included in our outcomes performance framework described below will be updated through this process and where possible will be incorporated in the next annual report. While many of the measures below are also currently included in Module 4 Forecast Service Performance, the review of metrics will bring increased alignment between these two modules of our statement of intent.

Outcomes Performance Framework

Health Outcome Measure –Life Expectancy

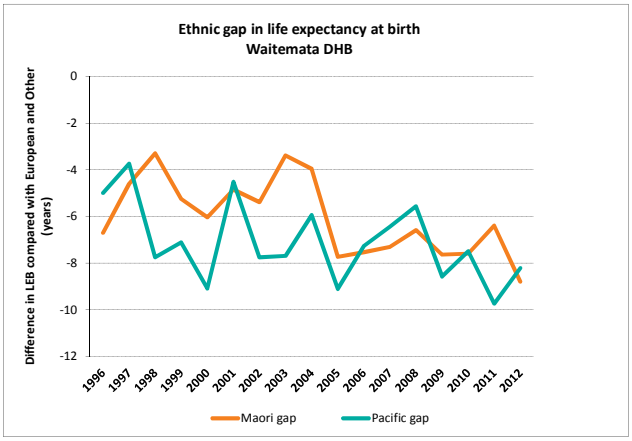


As a northern region DHB our overarching goal is to 'improve health outcomes and reduce disparities by delivering Better, Sooner, More Convenient services. We will do this in a way that meets future demand whilst living within our means'. Internationally recognised as a measure of population health status, increased life expectancy continues to be the high level outcome we monitor. For New Zealand as a whole the trend has been 2.7 years per decade over the last 16 years; Waitemata has seen an impressive trend of 3.3 years per decade.

Overall we continue to have the highest life expectancy in the country at around 84 years – almost three years higher than New Zealand as a whole. If the Waitemata district were a country we would have the highest life expectancy in the world (ahead of Japan, Switzerland and San Marino who all

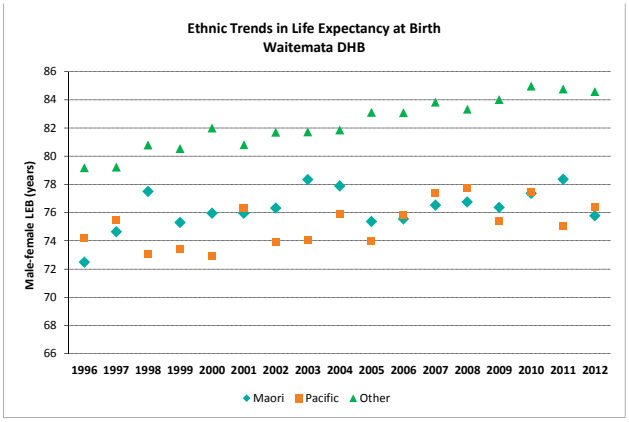
had life expectancies at birth in 2011 of 83 years[1]).

Health Outcome measure – ethnic gap in life expectancy at birth



While we have high life expectancy rates for Māori (76 years), Pacific (76 years) and non-Māori non-Pacific (85 years) compared to other New Zealanders, there are significant differences between the ethnic groups within our community (in 2012 there was an 8.8 year gap between Maori and non-Māori non-Pacific and an 8.2 year gap between Pacific and non-Māori non-Pacific ethnic groups).

Health Outcome measure – ethnic trends in life expectancy at birth



These life expectancy differences between ethnic groups have been widening over time because Māori and Pacific life expectency have only increased at 1.4 and 1.9 years per decade respectively, versus 3.5 years per decade for non-Māori non-Pacific. We want to reduce these life expectancy differences between the ethnic groups to zero.

Similarly, gender differences in life expectancy have declined significantly in Waitemata over the past 16 years, a trend that we would like to continue.

Analysis undertaken has found that cardiovascular disease, lung cancer, diabetes and obesity accounted for over half the difference in life expectancy between Māori and Pacific, and European ethnicities in Waitemata. Accidents, chronic obstructive airways disease, prostate cancer and female genital cancer also made significant contributions to the ethnic differences in life expectancy. These findings are reflected in our three outcome areas based on our purpose statements below and across our Board's priority populations and services .

To promote wellness

We focus at a population or community level for promoting wellness. Our role is to encourage healthy lifestyles in the whole population as well as more targeted activities for groups identified with specific health needs to improve overall health status. We will monitor inequalities and focus programmes and activities with a goal of reducing inequalities.

[11] [1] Global Health Observatory (http://apps.who.int/gho/data/node.main.3?lang=en)

We monitor the following outcome and impact measures, including monitoring inequalities, to ensure we maintain and improve wellness.

Outcomes	Impacts	Impact Measures
Healthy Lifestyles Our community's overall obesity rate is less than the New Zealand average as is our overall smoking prevalence. However our overall rates for vegetable intake (3+ servings per day) and being physically active (meeting physical activity guidelines in past 7 days) were lower than the national average. Our overall rates for hazard drinking and fruit intake (2+ servings per day) were similar to the national average.	We can impact healthy lifestyle behaviours through: • Our community action programme Enua Ola • Collaboration with other organisations that address life style issues such as regional sports organisations • Our diabetes self-management education programmes • Monitoring compliance with alcohol sales legislation • Implement the MoH funded maternal and child nutrition and physical activity programme *Refer below for smoking impacts.*	We monitor the impact of our programmes through: • The trend in obesity and morbid obesity prevalence and smoking prevalence based on National Health Survey • Percentage of licensed premises (on and club) that have been assessed as high risk (baseline 2011/12 92% target ≥95%) *Refer below for smoking impact measures.*
Well Children / Tamariki ora Many families living in Waitemata have better health than their national counterparts. However some, and in particular Māori and Pacific children, have poorer health status than other groups within the population.	We can impact our children's health through: • Improved access to oral health services • Improving immunisation rates (refer table below) • Hearing and vision testing • B4 school checks • Support for exclusive and full breast-feeding for less than 6 month olds • Throat swabbing clinics and other strategies to reduce rheumatic fever rates	We monitor the impact of our programmes and services through: • Percentage of children caries free and average Decayed , Missing and Filled Teeth (DMFT) of year 8 children by ethnic group • Percentage of children caries free and average decayed , missing and filled teeth of 5-year-old children by ethnic group • Rheumatic fever rates by ethnic group
Youth Mental health Mental health and alcohol and drug issues in young people have low rates of recognition. Barriers include lack of awareness and reluctance to seek help through conventional health services.	We can improve mental health wellness for our young people through: • access to primary mental health interventions, delivered through the District Wide Youth Health Hub • Providing school based health services (decile 1-3 schools) • Expand the use of a comprehensive Wellness check (HEEADSSS) • Ensuring up to date prevention relapse plans are completed for those with ongoing mental health issues	We can monitor the impact of our programmes through: • Youth access rates (0-18 years) to specialist drug and alcohol services reach 1.5% by June 2014 (regional target) • Percentage of young people with up to date prevention relapse plans for those with ongoing mental health issues

To prevent, ameliorate and cure ill health

We have a significant role to play in improving the management of ill health. At one end of the continuum we work with other agencies to minimise the negative impact on health outcomes of the social determinants eg housing and employment. Along the continuum we provide or fund prevention and disease screening programmes eg immunisation, smoking cessation and bowel screening; disease management programmes for long term conditions such as diabetes, rehabilitation services; and specialist hospital based services such as elective surgery and intensive care.

Our processes need to ensure rapid access to diagnosis and treatment for patients and consumers and a smoothly integrated transition between the providers of care. Similarly we need to ensure our services provide high quality and evidence based care.

We monitor the following outcome and impact measures, including inequalities within these, to achieve our purpose of preventing, ameliorating and curing ill health.

Outcomes	Impacts	Impact Measures
Prevalence of diabetes and cardiovascular disease Our overall diagnosed diabetes prevalence is the lowest in New Zealand, and our overall cardiovascular (ischemic heart disease and cerebrovascular) mortality rate is one of the lowest. Despite these low rates, ethnic differences present and over 800 of our community die of ischemic heart disease, stroke and diabetes each year. We want to reduce the disease and premature death in our community caused by diabetes and cardiovascular disease further	We can impact the prevalence of diabetes and cardiovascular disease and assist more patients to manage their chronic conditions through: • More heart and diabetes risk assessment checks for eligible populations, ensuring we reach those most at risk, including Māori and Pacific populations • Achieving national targets for cardiac revascularisation intervention rates ensuring equity of access for those most in need • Ensuring those with diabetes and a CVD risk ≥ 15% are prescribed the appropriate medications	We monitor the impact of these services through the following measures: • Heart and diabetes checks completed by ethnicity • Percentage of the enrolled population with diabetes aged 15-79 will have an HbA1c ≤ 64 mmol/mol by ethnicity • Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge. • Imputed quality adjusted life years gained from cardiac revascularisation procedures
Vaccine preventable childhood disease incidence Waitemata DHB now has one of the highest immunisation coverage rates in New Zealand. For example 92% of Waitemata children were fully immunised at 8 months (by 31 December 2012).	We can impact vaccine preventable childhood diseases through a comprehensive immunisation programme that intervenes early in life in order to reduce unnecessary suffering, provide better long term prognosis and better cost efficiency.	We monitor the impact of these services through the following measures: • Proportion of children fully immunised at 8 months • Proportion of children with 6 week immunisations completed on time • Proportion of children fully immunised at 2 years • Improve the immunisation rates for Māori and Pacific children. • Standardised hospital discharge information for vaccine preventable childhood

Outcomes	Impacts	Impact Measures
		diseases
Cancer incidence and survival We have the highest overall one year cancer survival rate in the country at 81.5%. We also have the lowest cancer mortality rates. In 2012 there were 3,130 people diagnosed with cancer within our district and approximately one third of our deaths are due to cancer.	We can impact cancer incidence and survival through: • Establishing a fully functioning Cancer Care Co-ordination service employing clinical nurse specialists across all tumour streams and including Māori and Pacific navigators, Faster Cancer Treatment tracking, and a Clinical Lead for Cancer Care, by 30 June 2014 • Reducing ethnic inequalities in cervical, breast and bowel screening rates • Commissioning additional endoscopy capacity, including specialists, to facilitate increasing colonoscopy throughput and reduce waiting times • Continuing to meet the national health targets for cancer waiting times and better help for smokers to quit.	We monitor the impact of these services through the following measures and targets: • Imputed years of life gained among Waitemata domiciled women through breast screening • Imputed QALYs gained through bowel screening of Waitemata residents • Standardised acute discharge rate and case-weights – trend and benchmarked against other DHBs for cancer related discharges • Reducing the equity gap for Māori, Pacific and Asian peoples • Ministry of Health produced DHB cancer survival rates
Access to elective surgery We achieved significantly above the national overall surgical intervention rates. We attained significantly above surgical intervention rates in cataract surgery and ENT and met national surgical intervention rates for orthopaedics and general surgery. We met the surgical intervention rate for major joints for the first time in 2012/13.	We can improve people's access to elective surgery with patients getting fast access to diagnostics and specialist assessment. We want patients to get the elective surgery they need without having unnecessary waits on booking lists.	We monitor the impact of elective services through the total QALYs gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows: Hip replacement (primary) = 0.85 Hip replacement (revision) = 0.15 Knee replacement (primary) = 0.8 Cataract = 0.46 CABG = 1.3 PCI = 1.64
Rapid access to appropriate acute care We have become a national leader in consistently admitting, discharging or transferring 95% of patients from our emergency departments within 6 hours. Between 2008 and 2012 we have seen an increase of 37% in the number of people attending our emergency departments with 104,653 attendances in 2012.	We can improve people's access to appropriate acute services through: • Reducing waiting times in our emergency departments • Working with primary care to provide integrated services for patients to ensure care is provided at the right time and in the right place	We monitor the impact of our strategies to improve access to appropriate acute care through: • Percentage of patients who are admitted, discharged or transferred from our emergency departments within 6 hours • Reduced rate of growth of emergency department presentations
Mental health We can improve the health status for those affected by mental	We can improve the health status for those affected by mental health illness through:	We measure the impact of our mental health services through the 28 readmission rate.

Outcomes	Impacts	Impact Measures
health illness through improved access. For 2011/12 this was 2.38% of our community.	• Increased access to specialist mental health services for all ethnic groups • Improving mental health services using relapse prevention planning • Shorter waits for non-urgent mental health and addiction services	
Smoking prevalence Our overall smoking prevalence is one of the lowest in the country. 16% of people living in our district are current smokers. There are significant ethnic differences with Māori and Pacific people more likely to smoke (33% and 21% respectively).	We can impact smoking prevalence through: • Implementing smokefree environment strategies, ie smokefree DHB facilities, smokefree policies for NGO providers • Continuing to achieve the better help for smokers to quit health target in our hospitals, and improving performance in primary care • Offering patients in general practice and hospitals help to quit	We monitor the impact of these services through the following measures: • Smoking cessation rates • Percentage of patients who smoke and are seen by a health practitioner in a public hospital or primary care setting offered brief advice and support to quit smoking • Annual ASH Year 10 survey data for WDHB (14-15 year olds) daily smoking rates over time
Infant mortality and sudden unexpected death of an infant (SUDI) Our infant mortality rate of 3 per 1000 live births (2005-2009) was the lowest in the country (along with Nelson Marlborough DHB). We had a mortality rate of only 0.4 per 1000 live births resulting from a sudden unexpected death of an infant ranking us fifth lowest of all DHBs. There are ethnic differences in rates of infant mortality and sudden unexpected death of an infant that we want to reduce.	We can impact infant mortality through: • Ensuring all children less than 6 years will have free access to after-hours care • Increasing the number of women who register with a Lead Maternity Carer by week 12 of their pregnancy • Developing systems which ensure every pregnant woman is enrolled with a PHO and registered with a GP and that those that smoke are offered advice and help to quit • Continuing to deliver our hospital-based Family Violence prevention and intervention programme.	The impact will be measured by infant mortality rate and rate for sudden unexpected death of an infant; however, due to the small number of deaths, data will have to be aggregated over years making it less sensitive to the services and interventions implemented. These progress measures include: • Proportion of after-hours free care for <6 years • Proportion of pregnant women registering with LMC by week 12 • Enrolment rate of pregnant women with a PHO
Health of older people We have an ageing population. Older people should receive coordinated and responsive health and disability services i.e. services that are accessible, flexible and timely. Integrating primary and community care across the health system enables patients to be treated closer to home with fewer acute and unplanned admissions into hospital. For those that	To improve the outcomes for older people and maximise years of life and quality of life, we want to: • support and enable older people to participate to their fullest ability in decisions about their health and well-being • streamline access for older people to all aspects of health services ensuring a 'right place, right time' experience	The impact of these strategies is measured by: • reduced readmission rates for 75+ years patients (target of 15% for 2013/14) • the percentage of older people (65+) receiving long-term home support who have a comprehensive clinical assessment and an individual care plan. During 2013/14 we will establish

Outcomes	Impacts	Impact Measures
require a hospital admission or other secondary or tertiary care, the services need to be responsive and connected. We need to ensure these services are structured and provided to make the best of use of health funding in order to meet increasing demands.	• develop a new model of care for Home and Community Support Services to provide better coordinated health and social services • grow integrated services to avoid hospital readmissions.	baselines for Home and Community Support Services core quality measures and benchmark with other DHBs.

To relieve suffering of those entrusted to our care

Our overarching purpose is to relieve suffering. Suffering can result from many causes including patient's physical or mental illness, the anxieties and emotional stresses associated with the illness, or by care which is slow or delayed, in error or culturally insensitive or disrespectful. We seek to reduce suffering through providing and funding effective services and through not causing any further suffering through inaction, error or neglect.

We will monitor the following outcomes, including monitoring inequalities, to ensure we relieve suffering of those entrusted to our care.

Outcomes	Impacts	Impact Measures
Improved patient experience Increasingly, there is evidence that quality is affected not only by the quality of technical care received, but also by the quality of the caring. There is also increasing evidence that good patient experience and good clinical quality go hand-in-hand.	We can improve patient experience through: • Our Patient and Family-Centred programme • Implementing the Family and Friends Test • Reduce time to respond to complaints	• Improved patient satisfaction • Developing a framework for patient experiences and a set of indicators measuring patient experiences
Quality and safety of services Patients and families need to: • be confident of the quality and safety of the care they will receive • know that the care they receive is best practice and evidenced based	We can improve quality through: • Improving safety through the First do no harm programme • Service improvement eg patient flow project • Being open and transparent by publishing our quality accounts alongside our annual report • Advance care planning	The impact of quality initiatives is monitored through: • Reduced adverse clinical events • Reduced falls in hospitals • Reduced medication errors • Reduced patient readmissions • Reduced post-surgical infection rates • Reduce Central Line Associated Bacteraemia (CLAB)
Reduced waiting times We have met the Elective surgery performance indicator (ESPI) waiting times for first specialist appointments and surgery have consistently met the national six month target for the last two years and in June 2013 achieved a five month waiting time. We want to provide our community with timely and	We can reduce waiting times through: • The shorter journey and productivity initiatives in elective surgery • Electronic referrals • Direct access for general practitioners to specialist advice, and to booking lists where appropriate • Improved access to timely	The impact of reduced waiting times is measured through: • Reduced readmissions • Reduced adverse clinical events

Outcomes	Impacts	Impact Measures
equitable access to elective surgery to support our community to live longer, healthier and more independent lives	diagnostics including CT and MRI	

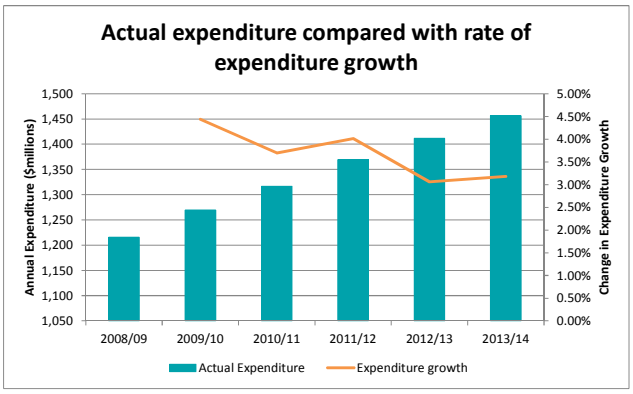
National Health Targets

Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Nationally, the volume of elective surgery will be increased by at least 4,000 discharges per year. Waitemata DHB will deliver 16,701 elective volumes during 2013/14
Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within four weeks
Increased immunisation	90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95% by December 2014
Better help for smokers to quit	90 percent of patients who smoke and are seen by a health practitioner in primary care and 95 percent in public hospitals, are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit
More heart and diabetes checks:	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

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 2013/14. The new financial year will see a focus for the areas of more heart and diabetes checks and better help for smokers to quit – primary care especially. We see the priorities we have developed for 2013/14 working together with the focus on health targets to deliver quality health care to our community.

Efficient and Effective Delivery of Health Services

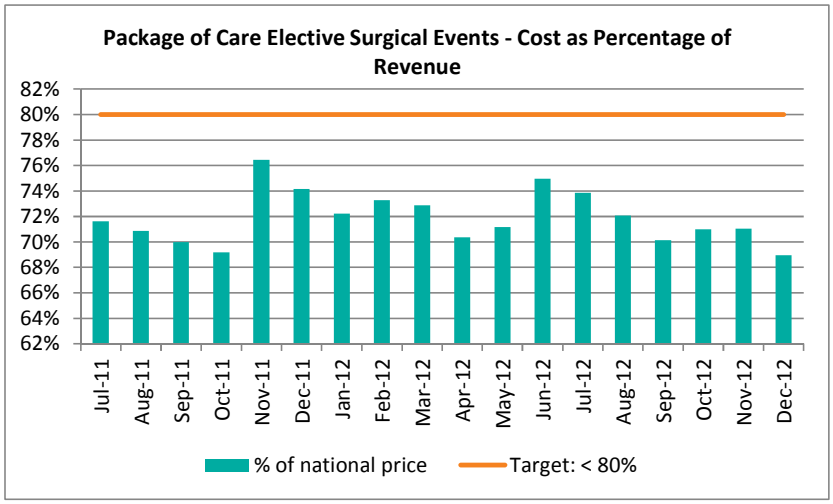
In addition to ensuring we improve the health outcomes for our community we are also focused on the sustainability of our organisation. DHBs are required "to ensure they seek the optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs". We are also required to operate in a financially responsible manner and must endeavour to cover all our annual costs from our annual income. We will continue to ensure we remain a sustainable organisation which manages its resources efficiently and achieves a break-even position each year. For example our rate of expenditure growth has decreased over the last 5 years (refer graph below).



We have lived within our means for the past four years, achieving year-end financial results better than approved plans and more recently, generating surpluses that have been reinvested into capital programmes to ensure that we continue to meet the health service needs of our growing population. This required providing services in a more efficient and cost effective way and this has been achieved through our business transformation programme and through involving our clinical staff in our decision-making processes.

How will we know we have provided the most effective and efficient delivery of health services?

- A surplus of $1M achieved for 2013/14 and 2014/15 and breakeven financial result achieved for 2015/16
- Business Transformation savings of $16.9M as outlined in the annual plan financial template or any additional savings achieved for the 2013/14 financial year
- Specific business transformation initiatives implemented and savings identified achieved by year end
- Agreed collaboration work streams at a national, regional, sub-regional and local and locality level implemented by year end and savings achieved. These initiatives include working with other DHBs and our PHO partners reviewing models of care and service configurations to ensure efficient and effective service delivery
- healthAlliance and Health Benefit Limited savings initiatives implemented and savings achieved by year end
- Hospital quality and productivity analysed and monitored against national benchmarks and against health outcomes
- Regional health plan work streams fully implemented
- Capped FTE count maintained at final agreed budget levels
- Improvements to key measures including - improved inpatient acute and elective length of stay and reduced acute readmissions to hospital; reduced waiting times for elective surgery, in our emergency departments and for cancer treatment, and the cost of packages of care compared with national price (refer graph below).



MODULE 3: Managing our Business

Managing our Business

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

Organisational performance management

We have developed an organisational performance framework which links our high-level outcomes framework with day to day activity. The organisational performance monitoring processes in place include annual reporting, quarterly and monthly Board and Committee reporting of health targets and key performance measures, monthly reporting against annual plan deliverables, weekly health target reporting and ongoing analysis of inter-district flow performance, monitoring of responsibility centre performance and services analysis.

We also have performance monitoring built into our human resource processes, 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

We continue to monitor our risk management practices to ensure we were meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. We have developed a joint risk management framework with Auckland DHB. This enables both DHBs to be consistent in the approach to managing and controlling risks particularly where risks are similar and also in consideration of risks that may arise from the collaboration work underway.

Asset Management

Asset Management Plan Development

Waitemata DHB provided asset management information to the National Health Board as part of the first draft of the financial templates for the 2013/14 Annual Plan. Input was also provided for the development of the Northern Region Asset Management Plan (AMP).

We are developing a detailed and updated Asset Management Plan expected to be completed by 30 June 2013. The Asset Management Plan outlines our current physical asset base used in delivering health services, the condition of the assets, refurbishment, upgrades and replacement requirements over the long term. The Asset Management Plan also outlines the key strategic projects planned for the medium term. Overall, the Asset Management Plan supports investment decisions by providing asset replacement profiles which facilitate management and ongoing maintenance of the current asset base as well as informing future asset requirements to continue to meet the growing demand for health services provided by our DHB.

To inform the Asset Management Plan development, we have completed a number of asset management improvement initiatives including the following:

- **Clinical Equipment Asset Verification and Cataloguing:** We have reviewed, verified and created a catalogue for high value clinical equipment assets with a value of $10,000 or more (these represent 80% of total clinical equipment assets). Not included in this assessment are dental (to be reviewed in 2013/14 post disposal of surplus equipment) and breast screening equipment. .
- **Buildings Condition Assessments:** We have completed condition assessments for all buildings owned by Waitemata DHB with assessments completed up to building room level. The output of this is useful for establishing building maintenance and replacement programmes.
- **Seismic Compliance Assessment:** Waitemata buildings have been assessed for seismic compliance to inform facility modernisation and upgrade programmes.
- **Motor Vehicles:** A motor vehicle verification and condition assessment exercise is underway with the services for the Waitemata vehicle fleet. Significant replacements have been implemented in 2012/13.
- **Site Master Planning**: Work has been undertaken to confirm the key strategic capital projects and timing of these in the medium to long term, including consideration of financing options for these. These will be discussed in the Asset Management Plan.
- **Health Services Planning**: Health Services Planning remains a key outstanding work stream to inform the overall longer term asset requirements.
- **Asset Management Plan Improvement Projects**: Key local Asset Management Plan improvement projects and regional considerations will be discussed in detail in the updated Asset Management Plan

Facilities Modernisation

We are rapidly progressing our facilities modernisation in order to improve the quality of services, expand capacity and meet service demand, enable service transfers from other DHBs (mainly Auckland DHB), improve productivity and efficiency and meet legislative compliance. This includes the following strategic capital projects:

- The Lakeview Extension project has been completed successfully resulting in modernised emergency services, remodelled cardiology services and expanded radiology services
- The Car Park project has expanded car parking space at both North Shore and Waitakere Hospitals, thus future proofing the sites' requirements for parking space into the future
- The business case for building a new Mental Health Unit to replace Taharoto was approved by the Minister in 2012 and is now being implemented
- The business case to implement remedial works for the leaky buildings at Mason Clinic was approved by the Board and is now being implemented
- The business case to implement the second phase of the transfer of Renal Services' patients from Auckland DHB and to expand capacity for the Waitemata population was approved by the Board and is now being implemented
- The Elective Surgery Centre project approved by the Minister and aimed at increasing elective surgery capacity and efficiency in service delivery is progressing well and, on plan to be commissioned and fully operational from July 2013
- The business case for a new MRI machine was approved by the Board for North Shore Hospital to address current capacity constraints and enable future service expansions for the hospital
- Various other facility development projects continue to be implemented together with significant investments in information systems, technology and infrastructure.

Emergency planning

The Waitemata DHB Emergency Planning and Response Team has a DHB-wide work plan that meets the requirements of the Operating Policy Framework and ensures the readiness of our DHB to provide a sustainable response if an emergency arises. The work plan includes an up to date Health Emergency Plan, education/awareness programme with staff, update of service by service response plans and exercise programmes that include the wider health sector, ie residential aged care and primary care, beyond our provider arm services.

Waitemata DHB works closely with the Auckland region Health Coordinating Executive Group on the priority work plan supporting regional emergency planning and management and participates in the regional and national exercises. There is also a link with the regional Civil Defence and emergency services activities in the district and regionally to ensure timely notification and accurate communication and liaison in the event of an emergency.

Building Capability

Building our Workforce Culture

Our workforce is central to the delivery of the organisational primary purpose of “Best Care for Every One”. We are committed to building and maintaining a performance and patient focused culture. This culture change is our top priority and specific work is happening across all services to embed the values “Everyone Matters”, “With Compassion”, “Connected” and “Better, Best, Brilliant” into our practice. In the coming year new recruits to the organisation will be screened to ensure alignment with the values and purpose. Job descriptions, and recruiting and performance review processes will be aligned to reflect the new values. Further development of health heroes, staff recognition and reward programmes will be implemented to reinforce where the established behaviours aligned with the purpose and values are being demonstrated in all areas of patient care and organisational activity.

Clinical leadership is at the core of all we do. The Waitemata DHB enhanced care management and clinical leadership model will be implemented in chosen services over the year and Awhina Education activity will be an enabler to this work. Clinical leaders taking on the enhanced clinical leadership roles will undertake leadership development work in collaboration with the New Zealand Leadership Institute and Professor Richard Bohmer. Learning and development needs across the whole of the organisation will be reviewed to ensure that each specific clinical area has sufficient time and resources set aside for these activities.

Strengthening our Workforce Capacity

Our DHB will work with our regional partners to develop and implement regional workforce strategies with a focus on Government priority areas and targets and in our organisation to strengthen our workforce in relation to Culture, Capability, Capacity and Change Leadership.

The work streams associated with each of the four workforce strategy elements are detailed in the DHB Workforce Strategy 2012-2016 document in line with regional priorities established to support the achievement of the Regional Health Plan objectives as well as local priorities and requirements.

The Health Workforce New Zealand (HWNZ) and the Northern Regional Training Hub (NoRTH) priorities will be central components of those strategies which will be implemented by Awhina, Workforce Development and human resource department lead activity.

We are aware of the 70/20/10 model for the allocation of postgraduate medical education funds, and the Northern Region Health Plan takes account of this. Some of the metrics still need to be

defined, and as such we endeavour to work collaboratively as a region with the training hubs and HWNZ to achieve these targets.

The activities and governance of the training hub, for the 2013/2014 year, will be more closely aligned with the Northern Region Health Plan as the former NoRTH and NDSA organisations have been amalgamated into the Northern Regional Alliance (NRA). NRA and in particular the training hub will work closely with the DHBs, HWNZ, tertiary education providers and the Northern Region Clinical Leaders Forum to implement its work plan

Our current workforce

Workforce Group	Headcount	FTE
Medical	709	635.3
Nursing	2353	1902.6
Midwifery	136	83.7
Allied Health	1031	888.7
Technical & Scientific	375	300.7
Care & Support	701	586.2
Corporate & Other	1192	1026.3
Grand Total	**6497**	**5423.4**

Leader Data is accurate as at 31 December 2012

Information Communication Technology

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

The Northern Regional Information Strategy (RIS 2010-20), and the Northern Region Information Systems Implementation Plan set the direction on information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for us to achieve its clinical and business objectives.

Fundamental to the achievement of these objectives is the performance of our shared services support agency, healthAlliance NZ Ltd. The Northern Region IS Leadership Group comprising representatives from each DHB and healthAlliance has been established to:

- Define the business requirements of the regional DHBs in IS shared services
- Provide strategic IS direction for the region
- Monitor performance of IS shared services in line with regional priorities and requirements
- Oversee the progress on the implementation of the Price Waterhouse Cooper Performance Improvement Programme
- Oversee the IT resilience work remediation
- Prioritise regional capital IS requests and IS projects
- Monitor key projects to ensure they are progressed according to agreed timeframes.

At the same time, historic underinvestment in IT infrastructure has resulted in an inherent service continuity risk for IS services and a bow wave of infrastructure upgrade and system resilience requirements in the Northern Region. To address this, the Northern Region DHBs have prioritised IS investment in the following areas:

- Microsoft software upgrades in workspace and infrastructure

- Clinical and business systems upgrades to ensure systems can operate in these upgraded workspace and infrastructure environments
- Ongoing improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- Improve resilience of IS systems to improve system availability, access, data integrity and security.

Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and the investment in our future systems. We also operate a 5 yearly replacement cycle for our computers to ensure these are regularly updated.

In addition to the investment in core infrastructure and IS support processes, Waitemata DHB as part of the Northern Region will continue to implement the National and Regional Information Strategy. Key projects of priority for Waitemata DHB include:

- G2012 Microsoft License Compliance
  - Upgrade of desktops to Microsoft Windows 7 and Office 2010
  - Compliance with Department of Internal Affairs mandate around use of supported software
- Clinical Data Repository (CDR) and Clinical Workstation (CW)
  - CDR is in place in the Northern Region. There are on-going enhancements and expansion of documents and information available in the repository
  - The Northern Region is committed to a single instance Concerto and will be working with Orion on a regional business case for a new single instance Clinical Workstation
- NZ ePrescription Service (NZePS)/ CPSA
  - GP scripting service to access community pharmacies is being implemented
- Maternity Clinical Information System
  - Deferred until 2014/15, following Counties Manukau DHB being the lead Northern Region DHB to implement
- Hospital ePharmacy
  - Supporting Safe Medication Management e-Prescribing system roll out across hospital services
- Legacy Patient Administration System (PAS)
  - Auckland DHB are taking the regional lead on implementing a northern regional PAS
- eDischarge
  - the new national standard for eDischarge will be rolled out to the hospital services
  - the eMedicines Reconciliation (eMR) will be rolled out to the hospital services
- Shared Care Planning
  - Continue rolling out the national shared care planning tool to manage more complex, long term conditions.

Quality and Safety

We are committed to becoming national leaders in delivering a patient centred, clinically driven high quality health care approach that has the patient, their family / whānau 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 2013/14 focuses on improving the patient experience, enhancing patient safety and increasing organisational capability regarding quality assurance and improvement; it is built on a foundation of clinical governance and is consistent with the recommended priorities from the New

Zealand Ministry of Health, the Health Safety and Quality Commission and the Northern Region Health Services Plan.

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

We have also developed an online hazard management system with Quality Hub linked to the risk management system. This method of hazard identification and management will result in Waitemata DHB preventing harm. The trial with the Health of Older People Service started in February 2013 with roll-out to the whole organisation planned during 2013. Many DHBs are shown an interest including Auckland DHB, Northland Counties Manukau DHB and Waikato, and Health Benefits Limited.

Patient safety will include increasing the immunity status of our staff across the organisation. This is important to protect our staff, our patients, our budget and reputation for infectious disease control. New staff are being encouraged to be immunised. Existing staff are more difficult but gradually compliance is increasing due to contact tracing, blood and body fluid exposures follow-up. Policy is being developed for high risk areas particularly considering mandatory vaccination to reduce patient, staff and organisation risk.

Organisational Health

Equal Employment Opportunities

We strive to be a good employer at all ages and stages of our employees' careers. The DHB is aware of its legal and ethical obligations in this regard. The DHB is equally aware that good employment practises are a critical aid in the building of a reputation which attracts and retains top health professionals who embody the DHB's values and patient centred culture in their practice and contribution to organisational life.

The DHB's Good Employer policy makes clear that we will provide:

- Good and safe working conditions
- An equal employment opportunities programme
- Recognition of the employment requirements of women
- Recognition of the employment requirements of men
- Recognition of the employment requirements of people with disabilities
- The impartial selection of suitably qualified persons for employment
- Recognition of the aims, aspirations, 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.

Staying On is an innovative development programme designed to assist WDHB and our people adapt to the age wave. It is a strategic whole of organisation approach aimed at creating an engaged culture and supports our desire to be an employer of choice at all ages and stages of a health professional's career. Staying On is built on three pillars: staying engaged, staying healthy and staying connected. It is a specific intervention designed to assist us to creatively and in the spirit of our purpose and values meet the requirements of our Good Employer policy.

Reporting and Consultation

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

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

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

Ability to Enter into Service Agreements

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

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

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

Memoranda of Understanding

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

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

- The University of Auckland
- AUT University
- Unitec Institute of Technology
- Massey University
- Otago Polytechnic
- The University of Otago
- The New Zealand Health Innovation Hub
- Coast to Coast Hauora Trust
- Waitemata PHO
- ProCare PHO
- Auckland Council

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

MODULE 4: Forecast Service Performance

Statement of Forecast Service Performance

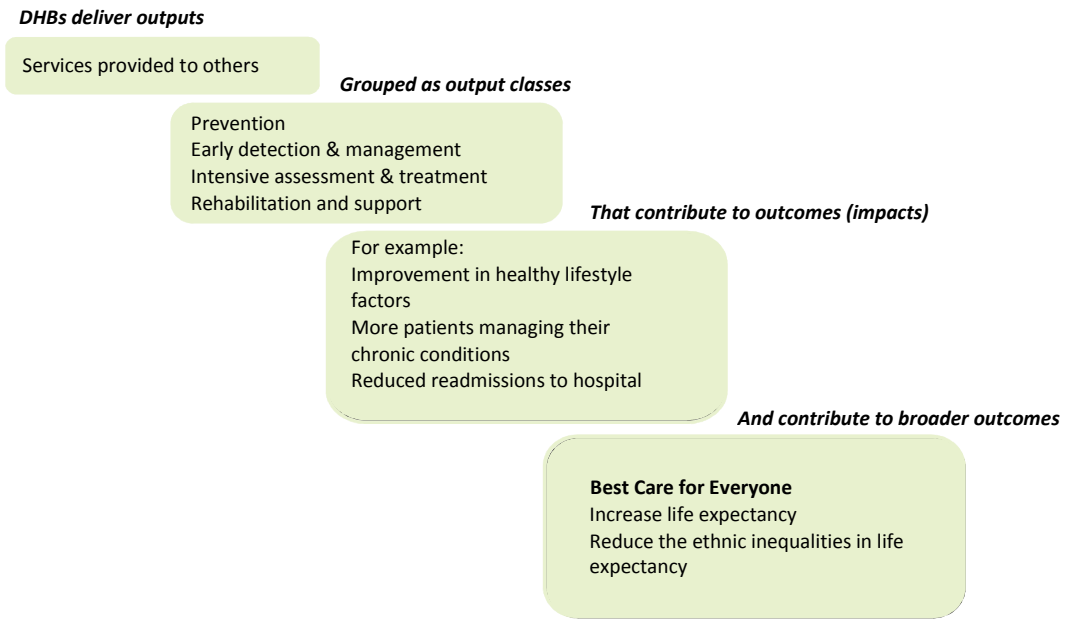
The statement of forecast service performance is very valuable for us as a way of 'telling our performance story' and of structuring our thinking about what we are producing and why we are producing it. The statement of forecast service performance is a requirement of the Crown Entities Act 2004 and sections 39 and 42 of the NZ Public Health and Disability Act 2000, and identifies outputs, measures, and performance targets for the 2013/14 year. Recent actual performance data is used as the baseline for targets.

We use only a few cornerstone measures here to cover what is a vast scope of business as usual activity. Those included here provide a reasonable representation of the services provided by a District Health Board. Measures within this Statement of Forecast Performance represent those activities we do to deliver our goals and objectives described in module 2 and also in our Annual Plan. Service Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

As noted in Module 2, metrics, targets and a reporting process will be developed to support our purpose statement and the enhanced clinical management model which will see changes to Module 2 and 4 in the future. The impacts described in Module 2 have been identified in the Statement of Forecast Service Performance with ☑.

Throughout the statement of forecast service performance the following 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 our DHB.

This logic framework has been used to help articulate how the work that is being carried out in our 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 that underpins this Statement of Forecast Service Performance

Some impacts may not be seen for many years. Therefore not all impact measures lend themselves to annual targets or even annual analysis. Some need to be viewed on a longer time frame, as part of our health needs analyses.

Outcomes Measurement Framework

Our focus for 2013/14 is based on the three key outcomes that comprise our purpose statement:

- To promote wellness
- To prevent, ameliorate and cure ill health
- To relieve suffering of those entrusted to our care.

A description of the impacts we expect to see contribute to these outcomes is described in Module 2 which links the outcomes and impacts with the national, regional and local strategic direction.

It is important that the actions we take during 2013/14 link to the expected impacts and outcomes sought in the future. The output classes, summarised below, which are described more fully later in the section, provide an overview of the quantity, quality and cost of activities undertaken by the DHB. Please also refer to the detailed planning framework in Module 2.

Key to the output classes for 2013/14

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

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

Cost of Outputs

Old Output Class Name	Hospital	Support	Primary	Public	Total
New Output Class Name	Intensive Assessment & Treatment	Rehabilitation and Support	Early Detection & Management	Prevention Services	Total
	Plan	Plan	Plan	Plan	Plan
Total Revenue	**833,380,082**	**212,840,747**	**383,204,664**	**28,071,839**	**1,457,497,331**
Expenditure					**0**
Personnel	416,005,596	31,388,286	59,644,011	9,739,947	**516,777,840**
Outsourced Services	44,415,750	5,612,219	6,370,233	1,040,268	**57,438,469**
Clinical Supplies	76,398,902	4,663,191	10,957,347	1,789,349	**93,808,789**
Infrastructure & Non-Clinical Supplie	78,241,030	5,486,692	11,221,550	1,832,494	**96,781,766**
Payments to Providers	215,597,932	166,151,204	296,094,671	13,846,660	**691,690,467**
Total Expenditure	**830,659,211**	**213,301,591**	**384,287,811**	**28,248,718**	**1,456,497,331**
Net Surplus / (Deficit)	**2,720,871**	**(460,844)**	**(1,083,148)**	**(176,879)**	**1,000,000**

Targets and Achievement

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

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

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

Key to Output Tables

Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target
↓	A decreased number indicates improved performance
↑	An increased number indicates improved performance

Output Class 1: 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

Prevention services prevent and ameliorate ill health 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. Delivery of health promotion activities (outputs) promotes wellness and encourages healthy lifestyles. For all services we seek to relieve suffering through providing and funding effective services and through not causing any further suffering through inaction or neglect.

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

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

Output: Health Protection

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline	Target 2013/14	Baseline Info	That will lead to these impacts
Communicable disease surveillance and control activities	**Notifiable Communicable Diseases:** Receive, investigate and manage notified communicable diseases	***Quantity*** Total number of communicable disease notifications per reporting period	Notifiable disease identification and investigation is an important component of the work of ARPHS and plays a major role in communicable disease control. These are indicators of the volume of output in this output class.	6,785	6,250 est.	2011/12	Public health risk from vaccine preventable and notifiable communicable diseases is minimised **Impacts measured by** Rate of confirmed and probable notifiable communicable disease cases per 100,000 persons per year
		Number of notifications investigated and found to be a *confirmed or probable case*		5,214	5,100 est.	2011/12	
		Number of notifications investigated and found to be *not a case*		1,371	918 est.	2011/12	
		Quality Percentage of notifications with case status recorded	Case status will be recorded when investigation of a case has been completed and EpiSurv (the national surveillance database) has been completed.	97%	≥95%	2011/12	

Output: Health Protection (continued…)

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline	Target 2013/14	Baseline Info	That will lead to these impacts
Health Protection (Physical Environment) Environmental control activities including: air quality; border health protection; burial and cremation; contaminated land; water quality; hazardous substances; radiation; sewage; waste management; resource management.	**Drinking water quality:** Assess compliance with the Drinking Water Standards (DWSNZ)	**Quantity** Number of DWSNZ Suppliers' Compliance Assessments conducted	ARPHS Promotes compliance with the Health (Drinking Water) Amendment Act 2007 and Health Act 1956 to optimise the safety and quality of drinking water available for public consumption in the Auckland region. This is an output measure.	272	270 est.	2011/12	The incidence and impact on health of environmental hazards are reduced **Impacts measured by** Proportion of drinking water suppliers that are compliant (not all suppliers are required by legislation to comply)
		Quality Percentage of reports provided to 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.	100%	100%	2011/12	
	HSNO (Hazardous Substances and New Organisms) Investigation and management of lead related events	**Quantity** Total number of lead notifications received	Minimising the harm from hazardous substances is a key role of ARPHS. Lead possesses intrinsic toxicity and is considered as a hazardous substance under the HSNO Act. ARPHS receives notifications of cases of raised blood lead levels and determines whether cases are either occupational or non-occupational. This is a measure of population exposure to lead as well as an output measure.	133	150 est.	2011/12	Rate of elevated serum lead notifications resulting from non-occupational exposure
		Number of confirmed cases that occur as a consequence of occupational exposure		81	90 est.	2011/12	
		Number of confirmed cases that occur as a consequence of non-occupational exposure		30	30 est.	2011/12	
		Quality Proportion of cases with probable source identified	Source of lead poisoning is identified through the process of case investigation. Thorough investigation increases the potential of source identification. This is a quality measure.	84%[2]	≥85%	2011/12	

[2] It is not clinically possible to determine an appropriate source with 100% reliability in all cases, especially in cases where exposure has been relatively low.

Output: Health Promotion

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline	Target 2013/14	Baseline Info	That will lead to these impacts
Health Promotion (Prevention of Alcohol and Drug Related Harm and Legislative and Leadership – Smokefree Environments Act 1990) Monitoring compliance with alcohol sales legislation	**Alcohol Legislative Programme:** Enforcement of Alcohol Legislation	**Quantity** Number of license premises (on* and club) risk assessed	In order to minimise the harm associated with the consumption of alcohol, ARPHS works to reduce the proportion of premises which sell alcohol that are of high or extreme risk. All on-license and club-license premises in the Auckland region are risk assessed. Extreme or high risk premises receive a pseudo-patron compliance check to ensure they are meeting their host responsibility obligations under the current liquor legislation. These are outputs and impact measures.	1269[3]	1200 est.	2011/12	Auckland liquor retailers provide safe environments for responsible drinking. Reduced alcohol related harm **Impacts measured by** Percentage of licensed premises (on and club) that have been assessed as high risk (baseline 2011/12 92% target ≥95%)☑ Proportion of joint Controlled Purchase Operations (CPOs) in which alcohol is sold to minors
		Number of license premises (on* and club) assessed as high risk		608[4]	400 est.	2011/12	
		Number of joint Controlled Purchase Operations (CPOs) conducted		N/A[5]	30% est.	N/A	
		Quality Percentage of premises risk assessed with overall risk rating recorded as per audit protocol	Controlled purchase operations monitor and enforce compliance with legislation. This indicator, by measuring compliance, offers a proxy for the likely impact of legislation and its enforcement on harmful alcohol consumption. These are outputs and impact measures.	237	200 est.	2011/12	

* an 'on- licence' authorises the holder to sell and supply liquor for consumption **on** the premises (e.g. pub) as opposed to off- licences (e.g. liquor stores)

[3] From October 2012, a new risk assessment tool was implemented. Before the tool was used, the risk of premises was not able to systematically assessed. The number included here represents the number of license applications processed in the year 2011/12 as a base to estimate the number of licenses that may be risk assessed in the year 2013/14. 100% of license applications will be risk assessed.

[4] The number included here represents the number of premises that were considered of high risk according to the criteria used before the implementation of the new assessment tool and that received a compliance check. It is expected that the assessment tool will provide a better method for identification of high risk premises; the target for 2013/14 has been set accordingly.

[5] There is no baseline data as the risk assessment tool has only been implemented recently

Output: Health Promotion (continued…)

We will undertake these activities	And deliver these outputs	Outputs measured by		Baseline	Target 2013/14	Baseline Info	That will lead to these impacts
Health Promotion (Prevention of Alcohol and Drug Related Harm and Legislative and Leadership – Smokefree Environments Act 1990) Monitoring compliance with Smokefree legislative programme	**Smokefree Legislative Programme:** Enforcement of the Smokefree Environments Act 1990	**Quantity** Number of retailer compliance checks conducted	Compliance checks are conducted with tobacco retailers to ensure they are meeting their obligations under the Smokefree Environments Act 1990.	571	500	2011/12	Smoking related mortality and morbidity is decreased in Auckland Smoking prevalence is reduced ☑ **Impacts measured by** Proportion of tobacco retailers who are compliant (Baseline 2011/12 82%, target 85%est) Proportion of Controlled Purchase Operations (CPOs) in which tobacco is sold to minors
		Number of Controlled Purchase Operations (CPOs) conducted	Preventing minors from accessing tobacco products contributes towards the prevention of smoking initiation. These are outputs and impact measures.	498	500 target	2011/12	
		Quality Outcome of operation is recorded as per audit protocol	Failure to comply with protocols would reflect a problem with quality.	82%	≥85% est.	2012/13 YTD	

Output: Health Policy / Legislation Advocacy and Advice

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline	Target 2013/14	Baseline Info	That will lead to these impacts
Health Policy/Legislation Advocacy and Advise **(Strengthening Public Health Action)** Analysis and comment on third party proposals that have the potential to impact on health outcomes in the Auckland region	**Healthy Public Policy:** Submissions on proposed legislation (bills and regulations), policies, strategies and projects that may impact on health outcomes	**Quantity** Numbers of submissions made (demand driven)	Submissions make up a high proportion of this work. The number reflects the volume of output although some involve more work than others	28	20 est.	2011/12	Policy makers are aware of the foreseeable health consequences of their decisions and incorporate changes to their proposals which are likely to deliver improved health outcomes **Impacts measured by** Narrative: Summary of feedback and evaluation of completed submissions
		Quality Percentage of submissions signed off by Medical Officer of Health and the Service Manager	Failure to comply with submission policy would indicate a problem with quality	100%	100% target	2011/12	

Note the services described in the above tables are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support all above measures is for all three metro Auckland DHBs.

Output: Population Based Screening

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Population breast screening of women aged 45-69 years	Eligible women screened for breast cancer	**Quantity** Screening coverage rates among eligible groups	Coverage is a standard measure of output from screening programmes.	n/a	68%	n/a	75%	2 years to end of Dec 2012	Increased survival / reduced mortality from breast cancer☑ Increased survival / reduced mortality from bowel cancer☑ **Impacts measured by** Imputed years of life gained among Waitemata domiciled women through breast screening☑ Imputed QALYs gained through bowel screening of Waitemata residents☑
		Quality Breastscreening - Proportion of women screened who report that their privacy was respected	Reflects the quality of the service	n/a	96.1%	n/a	95%	Q2 2013/14	
		Timeliness Proportion of women screened who receive their results within 10 working days	A timely service provides test results promptly	n/a	96.9%	n/a	95%	2012 calendar year	
Continue with bowel screening programme pilot	Eligible men and women screened for bowel cancer	**Quantity** Proportion of eligible population sent an invitation letter each two year screening cycle	Coverage is a standard measure of output from screening programmes.	*n/a*	100%	*n/a*	95%	2012 calendar year	
		Quality Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations.	This indicates whether patients felt that they were able to make an informed decision about colonoscopy and therefore reflects the quality of the service	*n/a*	97.7%	*n/a*	95%	Those who rated preparation as good or very good – annual survey Jun 12	
		Timeliness Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 50 working days	Prompt diagnostics is a timeliness indicator that ensures that screening is performed in a timely way.	*n/a*	87%	*n/a*	95%	2012 calendar year	

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Newborn hearing screening	Eligible newborns screening for hearing	**Quantity** Number/proportion of babies screened	Coverage is a standard measure of output from screening programmes	7810 or (96.31%)	n/a	100%	n/a	Dec 2011 – Nov 2012	Hearing loss is identified by 12 weeks of age for >=95% of children referred to audiology by the screening programme.
		Quality Referral rate to audiology <=4%	Reflects the quality of the service	1.6%	n/a	<=4%.	n/a	Dec 2011 – Nov 2012	
		Timeliness Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme.	A timely service provides prompt access	100%	n/a	>=95%	n/a	Dec 2011 – Nov 2012	

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 2: 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.

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

Contribution to outcomes

Ensuring good access to **early detection and management services** for all population groups, including prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions contributes to preventing, ameliorating and curing ill health. 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, and relief of suffering reduced, 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 / whānau confidence in the quality of the health system.

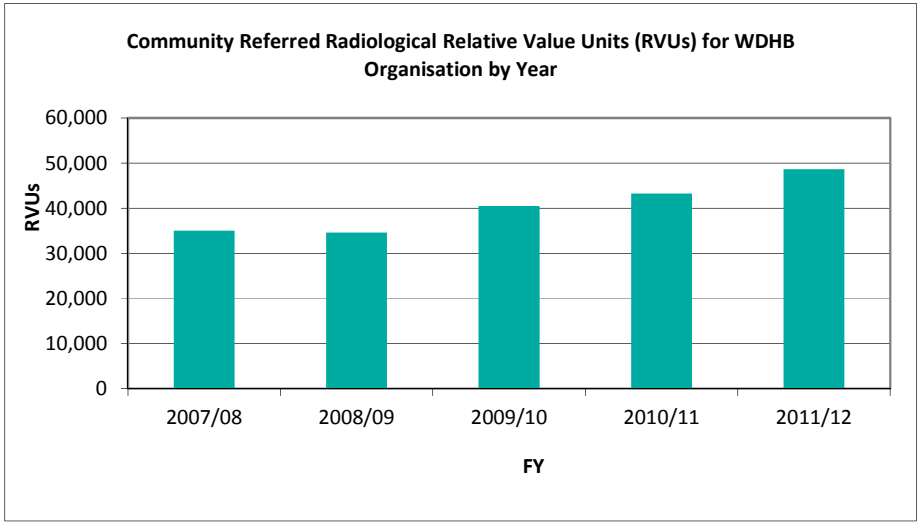
Effective early detection and management of patients reduces demand on more costly secondary and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

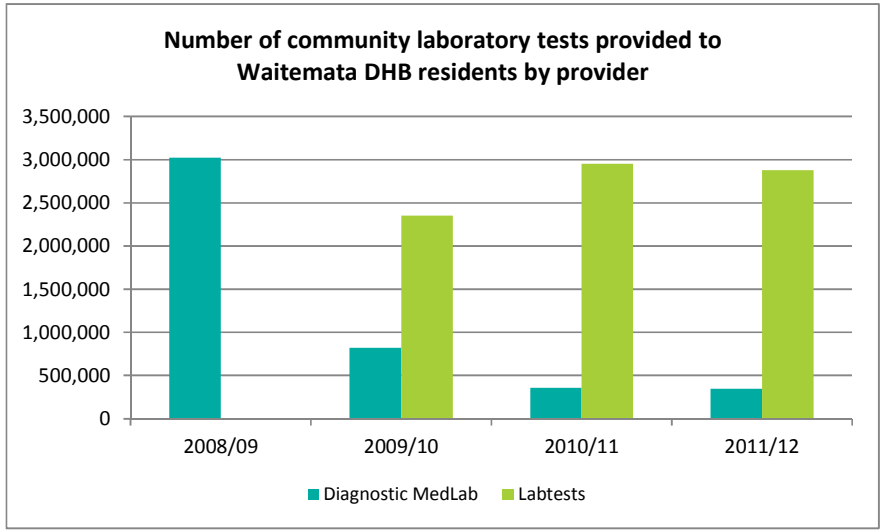
Output: Community Referred Testing & Diagnostics

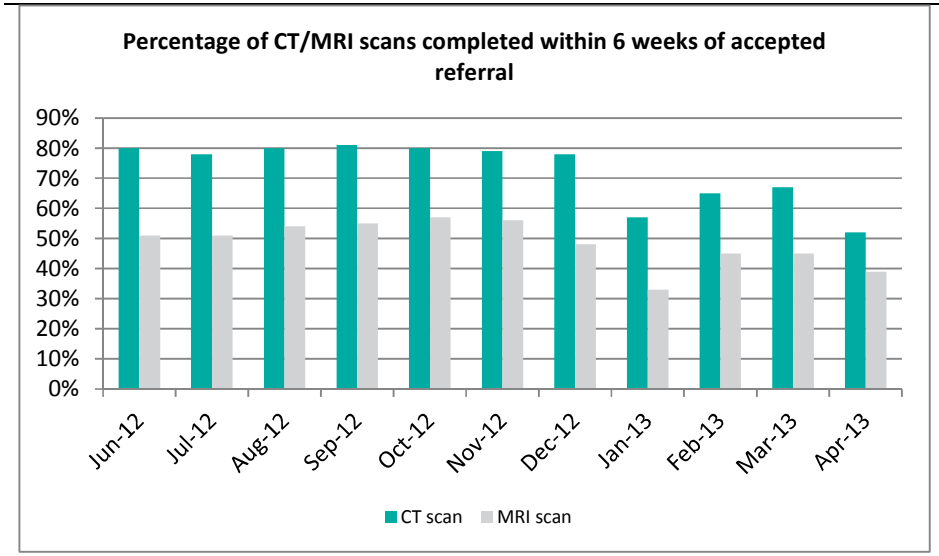
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Purchase and monitor community referred testing and diagnostic services including: • laboratory tests • radiological services for cardiology, neurology, audiology, endocrinology, respiratory, orthopaedics • pacemaker physiology tests • ante-natal screening	Community referred laboratory tests and other diagnostics services	**Quantity** Number community laboratory tests by provider	The no. of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services	*DML = 342,530*	*346,171*	Ω	Ω	2011/12	Prompt diagnosis of acute and chronic conditions. Patient reassurance in the case of negative results. Reduced demand on specialist outpatient appointments **Impacts measured by** The percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HbA1c) for assessing absolute CVD risk in the last five years. Proportion of patients attending First Specialist Appointments for back pain who have already had MRI imaging. (WDHB only)
				LTA = 2,581,254	*2,875,556*	Ω	Ω		
		Number radiological procedures referred by GPs to hospital	The no. of community referred radiological procedures is a direct indicator of the volume of output of community radiology diagnostic services	42,916	47,496	Ω	Ω	2011/12 The volume of radiological procedures referred by GPs to hospital in RVUs (PU code CS01001)	
		Quality Complaints as percentage of total no. of laboratory tests ◈	A high quality community laboratory diagnostic service will receive only a small number of complaints.	0.00001%		↓		As at Dec 2012	
		Timeliness 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.	6.3 mins	7.8 mins	< 30 mins	< 30 mins	14 Jan – 1 Mar 2013	
		85% of accepted community referrals for CT and 75% for MRI scans receive their scan within 6 weeks (42 days) by July 2014	Timely access to diagnostic testing makes an important contribution to good patient outcomes.	64%	56%	85%	85%	As at Feb 2013	

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

Trend graphs for selected output measures for community referred testing & diagnostics



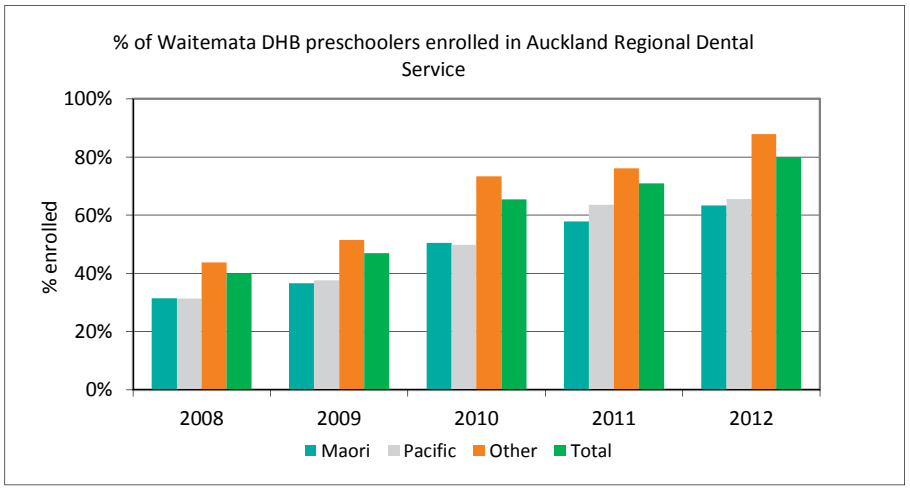


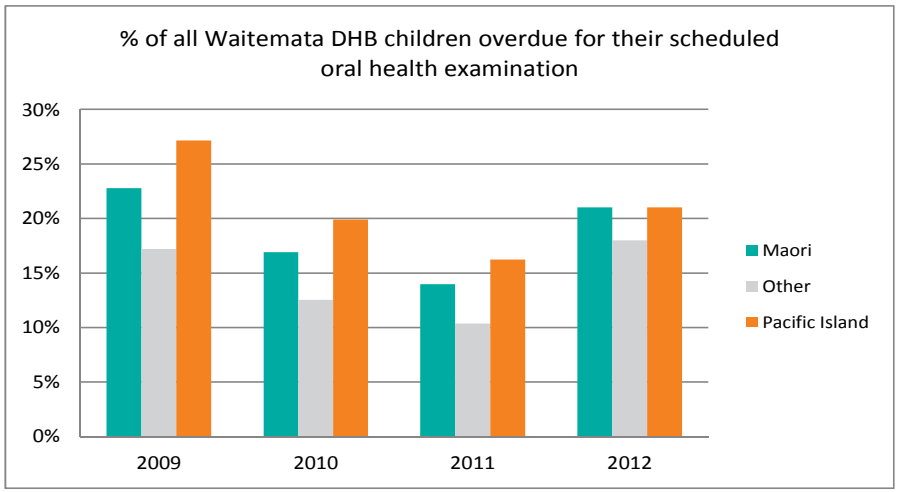


Output: Oral Health

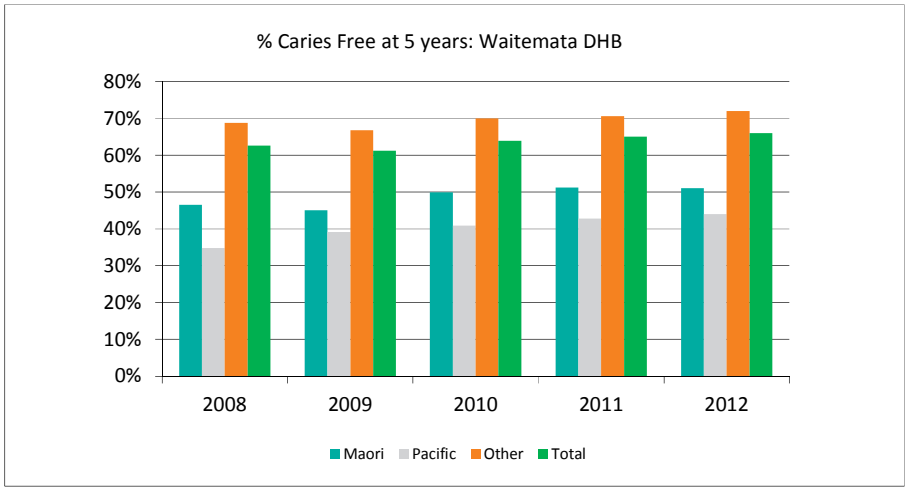
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Fund and/or provide a range of services for the metro Auckland region that promote, improve, maintain and restore good oral health including: • Health promotion activities targeting children and adolescents living in disadvantaged areas. Particularly Māori and Pacific • Oral health examination and oral health education provided to preschool children & their parents • Oral health examination and education provided to school age children and adolescents. • Oral health examination and pain relief provided to low income adults with oral health problems	Oral Health education Oral examinations and treatment among preschool children, school children, and adolescents.	**Quantity** Enrolment rates in children under five by ethnicity: • Māori • Pacific • Other • Total population	Output is directly related to the proportion of children enrolled in the service	 2,670 4,338 15,104 **22,162** (or 73%)	 4,525 3,158 20,413 **28,096** (or 80%)	**2013** 22,990 (76%) **2014** 80% enrolled	**2013** 32,195 (82%) **2014** 85%	2012 calendar year	Caries among children and adolescents is prevented, detected early and treated before major damage to teeth occurs Improvement of overall oral health with the reduction of inequalities among different ethnic groups **Impacts measured by** Percentage of children caries free and average Decayed, Missing and Filled Teeth (DMFT) of year 8 children by ethnic group☑ Percentage of children caries free and average decayed, missing and filled teeth of 5-year-old children by ethnic group☑
		Utilisation rates for adolescents	This is an indication of the volume of service in relation to the target population		69%	**2013** 85% **2014** 85%	**2013** 85% **2014** 85%	2011 calendar year	
		Number of visits of preschool, and school children to oral health services (including adolescents)	Provides an indication of the volume of service.	84,246	112,185	*n/a*	*n/a*	2012 calendar year	
		Quality Number of complaints in the financial year	A high quality service will receive low numbers of complaints	8	20	↓	↓	2012 calendar year	
		Timeliness Arrears rates by ethncity: - Māori - Pacific - Other - Total population	A timely oral health service will have low arrears rates	 18.2% 19.0% 19.5% 19.2%	 16.6% 19.9% 12.2% 13.7%	Overall 2013- 10% 2014- 10%		2011 calendar year	

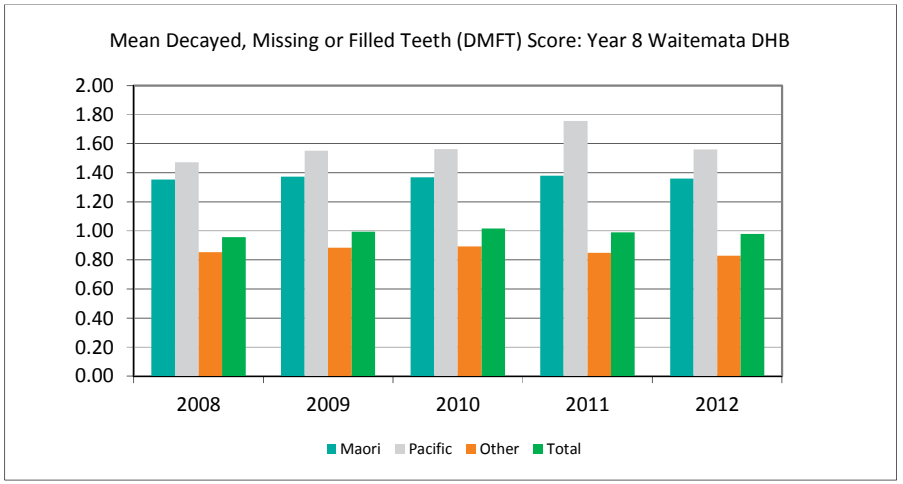
Trend graphs for selected output measures for oral health





Trend graphs for oral health impact measures



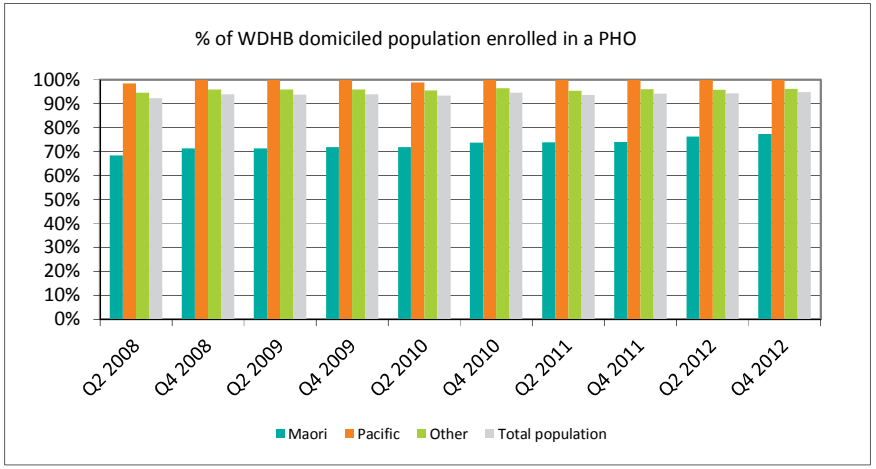


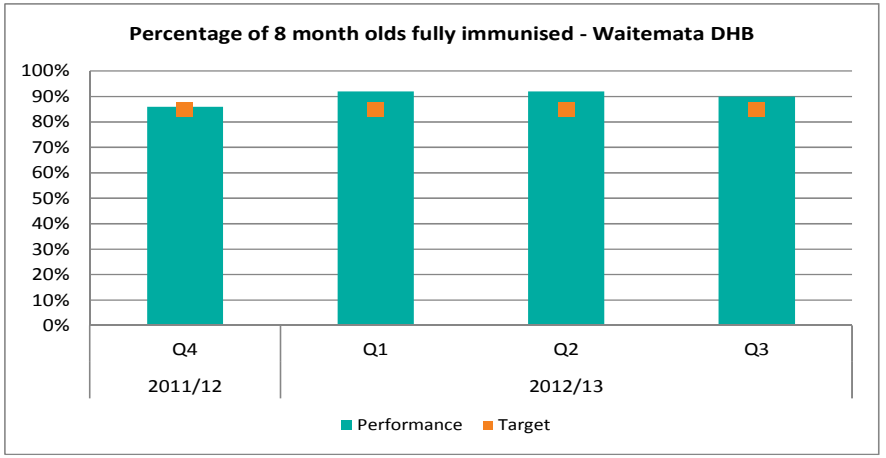
Output: Primary Health Care

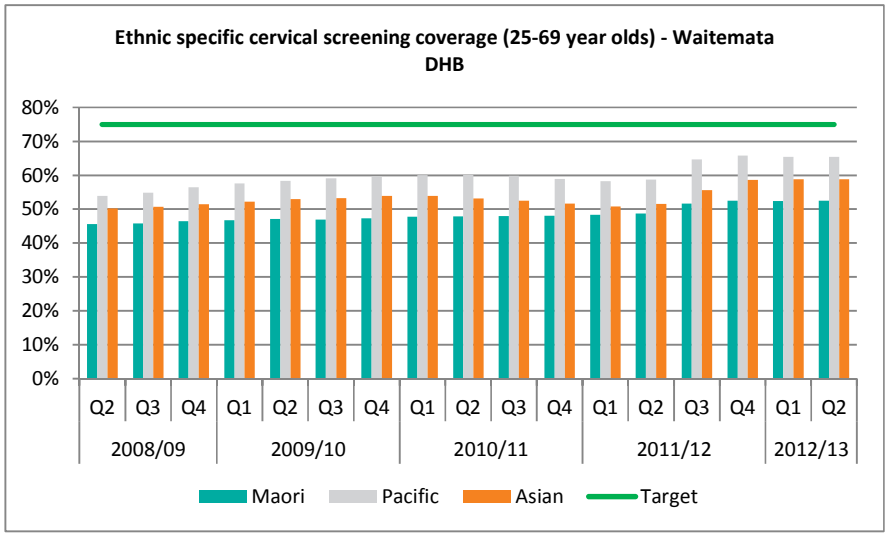
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Subsidise the provision of primary care services provided by GP teams, including certain specific health programmes e.g. CVD Risk assessment and management, immunisation and before schools checks Subsidise the provision of primary care services provided by Primary Health Organisations including diabetes coordination and services to improve access for high risk groups Subsidise Region-wide work to improve the performance of primary care through the GAIHN. Contract cancer care coordination (navigation) services for Māori and Pacific populations	Enrolment in PHO affiliated general practice teams. Primary care nurse and doctor consultations, diagnosis and treatment for acute and long term conditions as well as social support and advice to families, in enrolled populations. Preventive health care including immunisation, before schools checks, and advice and help to quit smoking. Referral to secondary care services when appropriate. Community referred diagnostic and pharmaceutical	**Quantity** Primary care enrolment rates	Primary care enrolment rates give an indication of access to primary care health services.	93%	95%	95%	95%	Q2 2012/13	Management and cure of treatable conditions. Prevention of illness. Maintenance of functional independence. Pain relief and reassurance. Minimising unnecessary use of high cost secondary care ("gate-keeping") **Impacts measured by** Reduced standardised acute discharge rate and case-weights – trend and benchmarked against other DHBs over time (effective primary health care should result in a static or reducing rate of acute admissions to hospital) ☑ Note: this includes vaccine preventable childhood diseases.
		Immunisation health target achievement - 90% of eight month olds fully immunised by July 2014☑	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 and the impact of our services in achieving heart immunity	91%	92%	90%	90%	Q2 2012/13	
		Cervical screening coverage	As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care	77.5%	75.7%	75%	75%	3 year coverage as at December 2012	
		Percentage of B4 School Checks completed	Coverage is a standard measure of output from screening programmes	54%	36%	90% (year end target)	90% (year end target)	As at Q2 2012/13 (ie. mid year)	
		Quality 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	41%	38%	↑	↑	As at December 2012	

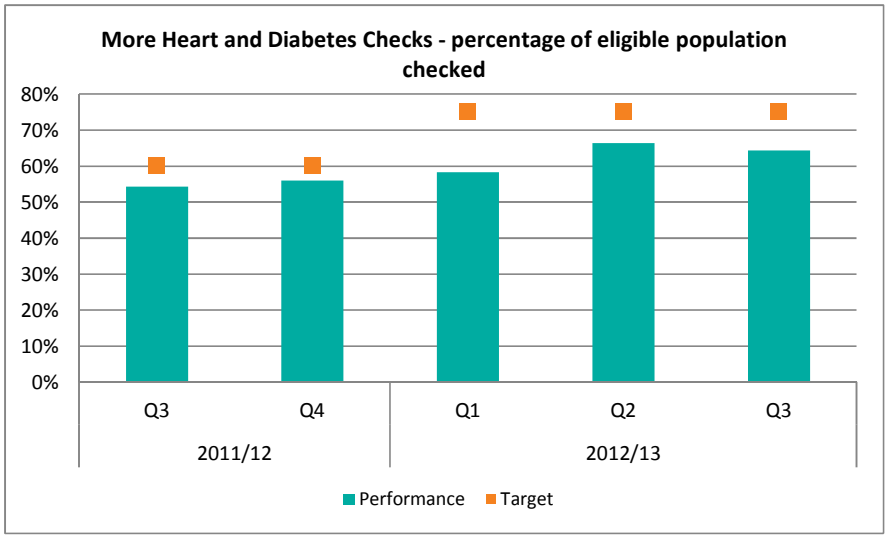
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
	outputs included in a separate output subclass]	Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and in the risk of the individuals contracting smoking related diseases	37%	38%	90%	90%	Q2 2012/13	
		Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	Ensuring long-term conditions are identified early and managed appropriately, will help improve the health and disability services people receive and aid in the promotion and protection of good health and independence	66.4%	54.1%	90%	90%	Q2 2012/13	
		Timeliness 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	305 per 10,000	429 per 10,000	Ω	Ω	2011/12	

Trend graphs for selected output measures for primary health care









Output: Pharmacy

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Subsidise the community based provision of prescribed pharmaceuticals.	Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations.	**Quantity** Total value of subsidy provided.	This indicates the total DHB contribution towards patients' community drug costs.	$132,776,975	$118,001,495	Ω	Ω	2011/12	Good access to effective pharmaceutical treatments. Lower per capita out of pocket and total expenditure on pharmaceuticals **Impacts measured by** Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge.
		Number of prescription items subsidised	Another indicator of overall volume of community pharmacy subsidy to our population.	6,421,850	6,532,756	Ω	Ω	2011/12	
		Number of Medicine Use Reviews conducted by community pharmacy (WDHB only)	Represents the extent to which MUR Services are being utilised to improve medicines adherence in at-risk groups	*n/a*	192	*n/a*	↑	2011/12 (initial consults)	
		Quality 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	96%	97%	100%	100%	2011/12	
		Timeliness The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	Represents the accessibility of after-hours pharmacy services to the population	98%	94%	95%	90%	As at Mar 2013	

Ω Demand driven forecast activity

Output Class 3: 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 prevents, ameliorates and cures ill health and relieves suffering. It also 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.

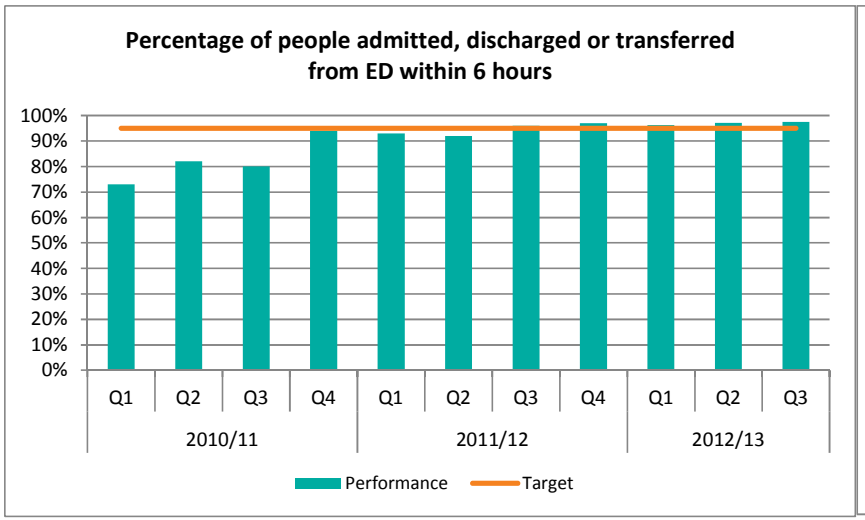
The overall patient experience, both as an outpatient and as an inpatient, is improved and suffering relieved with prompt service delivery, caring and courteous staff and comfortable, easily accessed facilities catering for all patients' needs.

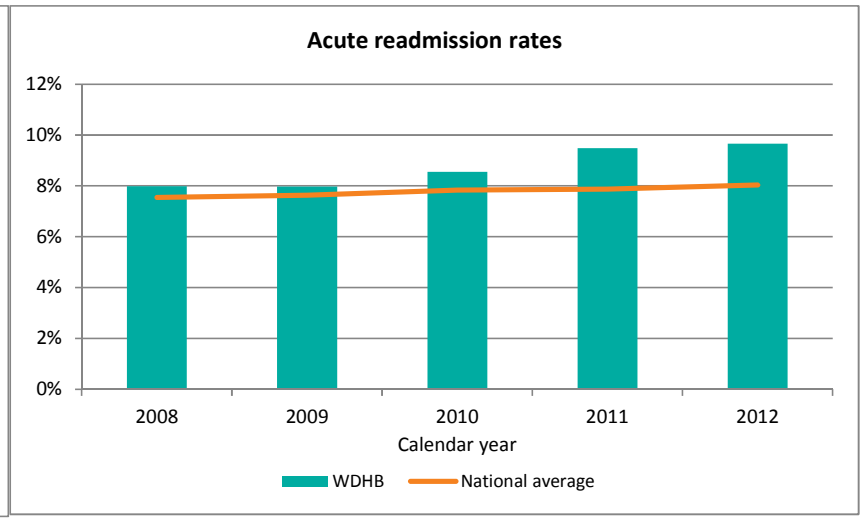
Efficient elective and acute service delivery and careful prioritisation of **intensive assessment and treatment** services maximise the cost-effectiveness of these services provided to our community.

Output: Acute Services

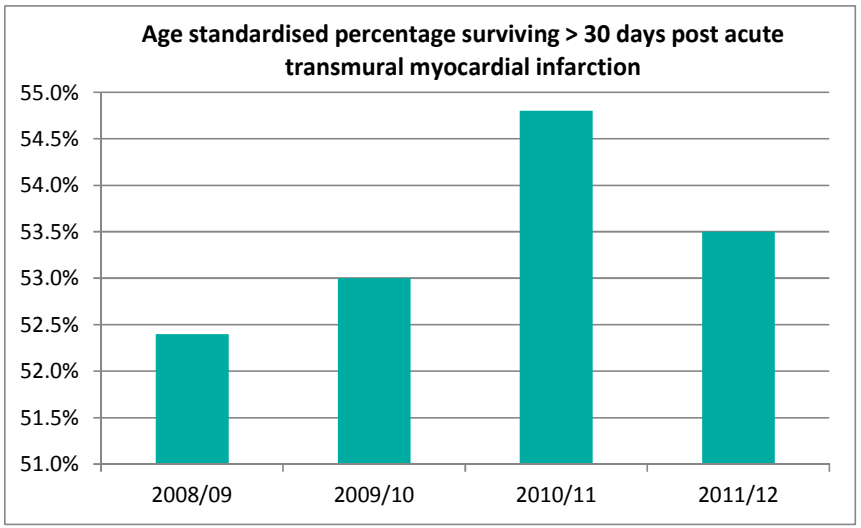
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Provide an emergency and acute care service with the following characteristics: • Timely access to all service components (including diagnostics) and appropriate timely discharge • Capacity to meet needs • Right treatment in the right place • Timely patient transfer to appropriate services from Emergency Department • Good access to support services in the community or primary care level to support patient recovery.	Acute inpatient services Emergency department services	**Quantity** Number of ED attendances (child and adult – ADHB only)	An indicator of the volume of emergency care provided to our population	95,659	103,458	Ω	Ω	2011/12	Effective and prompt resolution of medical and surgical emergencies and acute conditions Reduced mortality Improved patient experience of our services Improved engagement of clinicians and other health professionals Patients less likely to be readmitted **Impacts measured by** Age standardised 30 day survival from acute transmural myocardial infarction (WDHB only)
		Acute WIES total (DHB Provider)	An indicator of the volume of acute hospital service provided to our population	93,838	53,327	92,499	53,327	**ADHB** 2011/12 **WDHB** 2012	
		Quality Readmission rates – acute readmissions within 28 days	Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care	10.2%	9.6%	10.2%	9%	Year to 31 Dec 2012	
		Timeliness 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	95%	97%	95%	95%	Q2 2011/12	
		Compliance with national health target of all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy	Ensuring timely access to cancer treatment for everyone needing it will support public trust in the health and disability system; and that these services can be used with confidence	Chemo 100% Radiation 100%	Chemo 100% Radiation 100%	100%	100%	Q2 2012/13	

Trend graphs for selected output measures for acute services





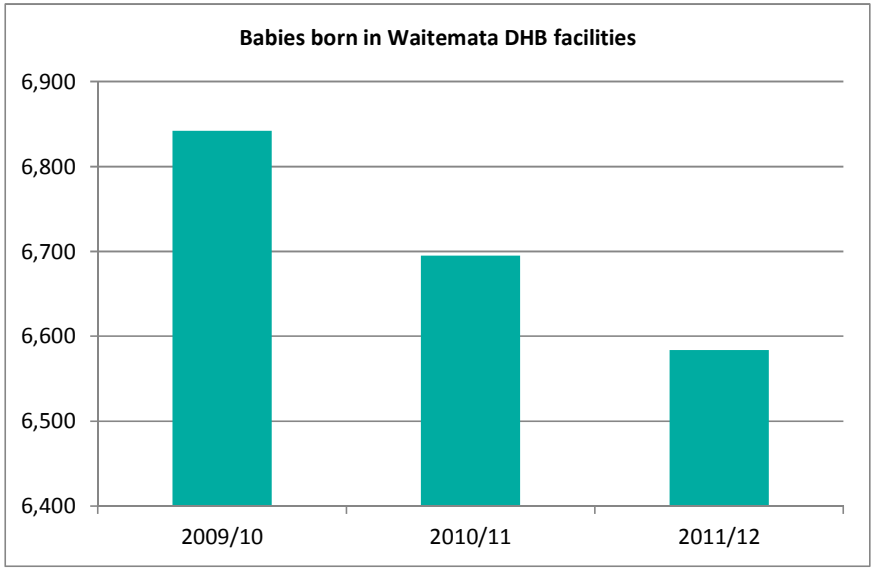
Trend graph for acute services impact measure

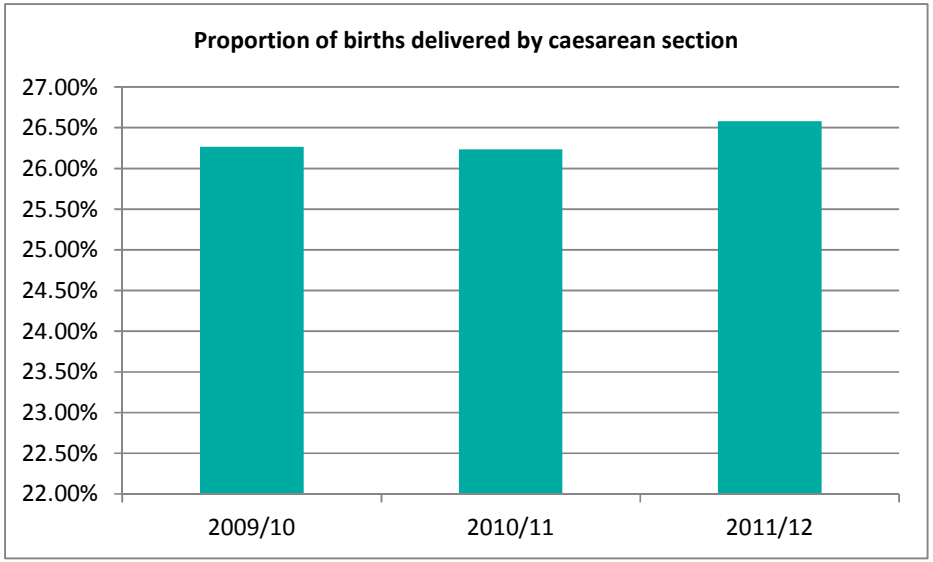


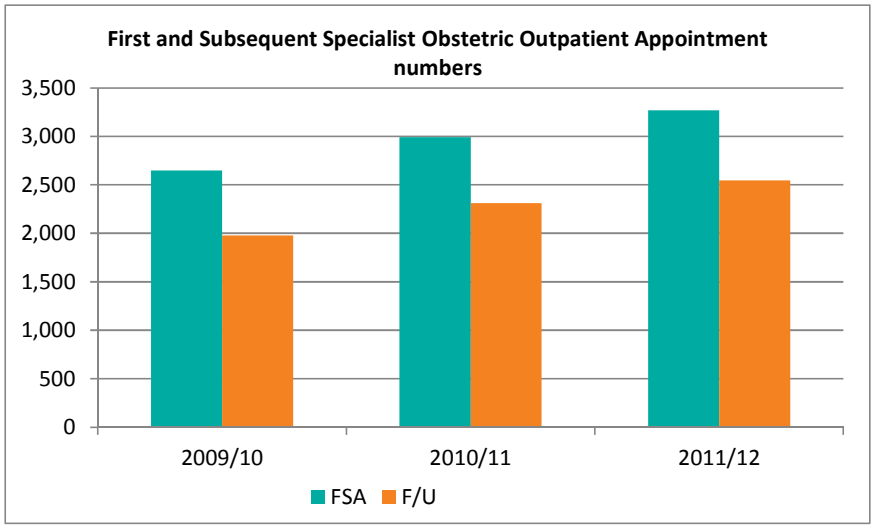
Output: Maternity

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Provide readily accessible maternity, obstetric and neonatal care services	Non-specialist antenatal consultations Obstetric antenatal consultations Postnatal inpatient and outpatient care Labour and birth services Specialist neo-natal inpatient and outpatient care Amniocentesis	**Quantity** Number of births	An indicator of volume of service provide to our population	7,863	6,873	Ω	Ω	2012 calendar year	Safer childbirth. Healthier children. **Impacts measured by** APGAR score ≤ 6 at 5 mins for live term infants Blood loss ≥ 1500 ml during first 24 hours following a vaginal birth Blood loss ≥ 1500mls during first 24 hours following caesarean birth Families satisfaction with care (ADHB only)
		Number of first obstetric consultations	An indicator of volume of service provide to our population	4,256	3,269	Ω	Ω	2011/12	
		Number of subsequent obstetric consults	An indicator of volume of service provide to our population	4,348	2,546	Ω	Ω	2011/12	
		Quality Proportion of all births delivered by caesarean section	An indicator of volume of service provide to our population	33.4%	28.8%	↓	↓	2012 calendar year	
		Established exclusive breastfeeding at discharge excluding NICU admissions	A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge	80.3%	77.77%	75%	75%	2012 calendar year	
		Third/fourth degree tears for all primiparous vaginal births	Women's Hospital Australasia (WHA) core maternity indicator: 3rd/4th degree tears major complication of vaginal delivery; significant impact on quality of life	5.1%	3.3%	↓	↓	2012 calendar year	
		Admission of term babies to NICU	An indicator of intra-partum care	5.9%	n/a	↓	n/a	2012 calendar year	
		Timeliness Number of women booking before end of 1st trimester	An indicator of the degree to which services are accessible and equitably available. Early booking is associated with better maternal and foetal health outcomes	*New measure*	*New measure*	↑	↑		

Trend graphs for selected output measures for maternity services







Output: Elective (Inpatient/Outpatient)

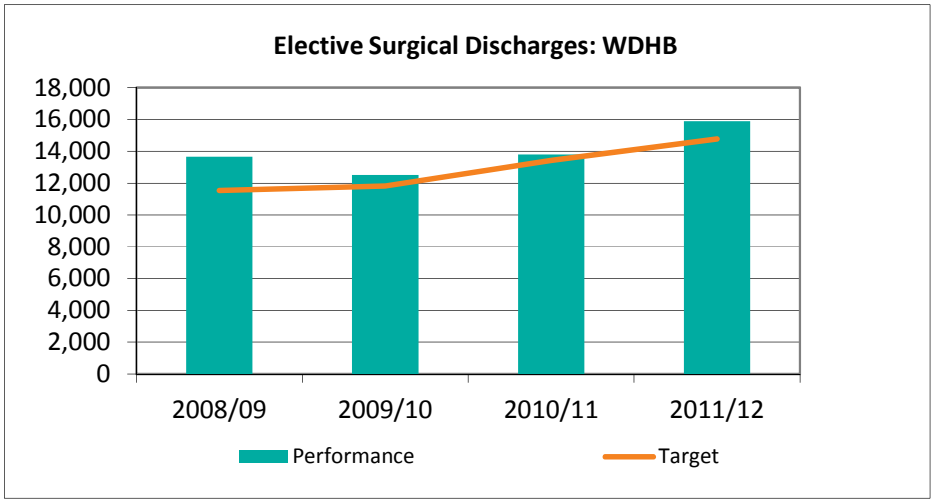
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Provide and purchase elective inpatient and outpatient services	Elective inpatient services Elective outpatient services	**Quantity** Delivery of health target for elective surgical discharges (Health target)	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)	11,981	15,891	13,499	16,701	2011/12	Restoration of functional independence Increased life expectancy☑ Improved surgical infection rates☑ Improved waiting times for our services Fewer adverse clinical events☑ Patients less likely to be readmitted **Impacts measured by** Total QALYs[6] gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows: Hip replacement
		Surgical intervention rate. (WDHB only)	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	16.49 (Joints) 32.78 (Cataracts) 5.34 (Cardiac) 12.22 (PCR) 31.15 (Angio)	21.59 36.76 7.75 13.10 40.78	21 27 6.2 11.9 33.9	21 27 6.5 11.9 33.9	Year ending Sep 2012	
		Number of first specialist assessment (FSA) outpatient consultations	FSA consultations are important component of our elective services output and the total number is a good indicator of the volume of our output	83,795	33,612[7]	83,284	Ω	2011/12	
		Quality Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Health Quality and Safety Commission (HQSC) defined	*New measure*	*New measure*	↓	↓	n/a	

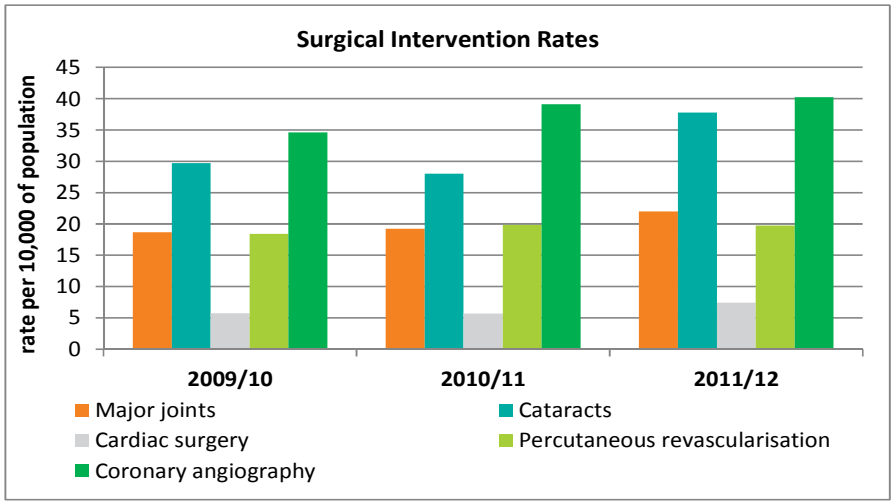
[6] QALY – Quality Adjusted Life Year. QALY gains are discounted by 3% per annum. Specific values cited here for each procedure are based on review of the international literature.

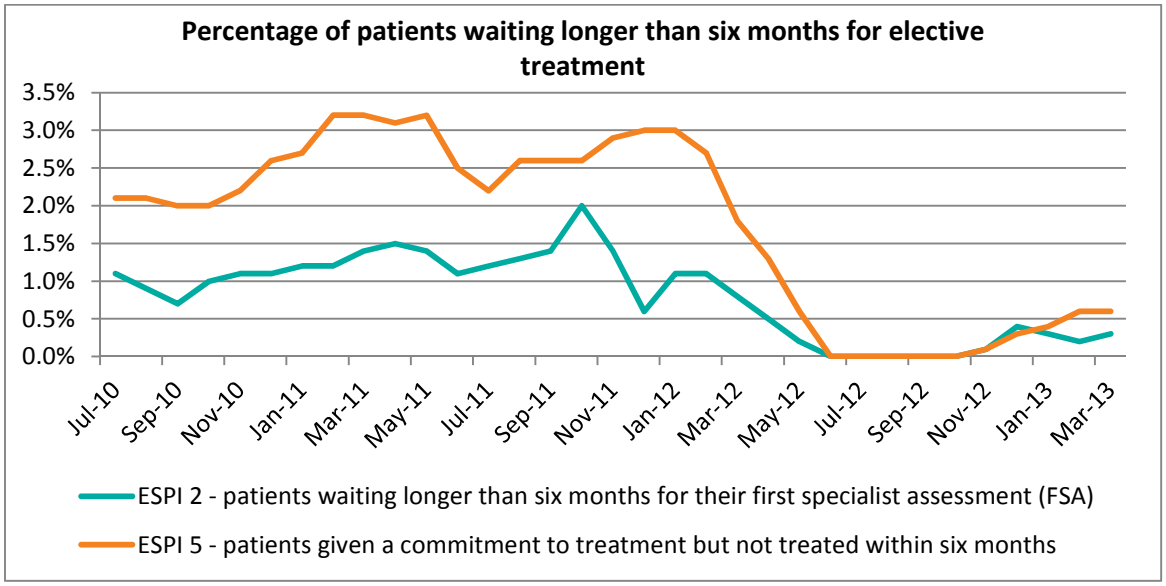
[7] 2011/12 baseline. FSA PUCs only and only for DHB of service, not for whole population.

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
		Post-operative sepsis and DVT/PE rates - HQSC	Health Quality and Safety Commission (HQSC) defined	*New measure*	*New measure*	↓	↓	n/a	(primary) = 0.85 Hip replacement (revision) = 0.15 Knee replacement (primary) = 0.8 Cataract = 0.46 CABG = 1.3 PCI = 1.64 (WDHB only) ☑
		Percentage of respondents who rate their care and treatment as very good or excellent (ADHB only)	Reflects the quality of the service	84%	*n/a*	90%	*n/a*	Feb 2013	
		Timeliness Patients waiting longer than five 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	0.5%	0.3%	0%	0%	Jan-13	Surgical Intervention rate (ADHB only)
		Patients given a commitment to treatment but not treated within five 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	1.2%	0.9%	0%	0%	Jan-13	

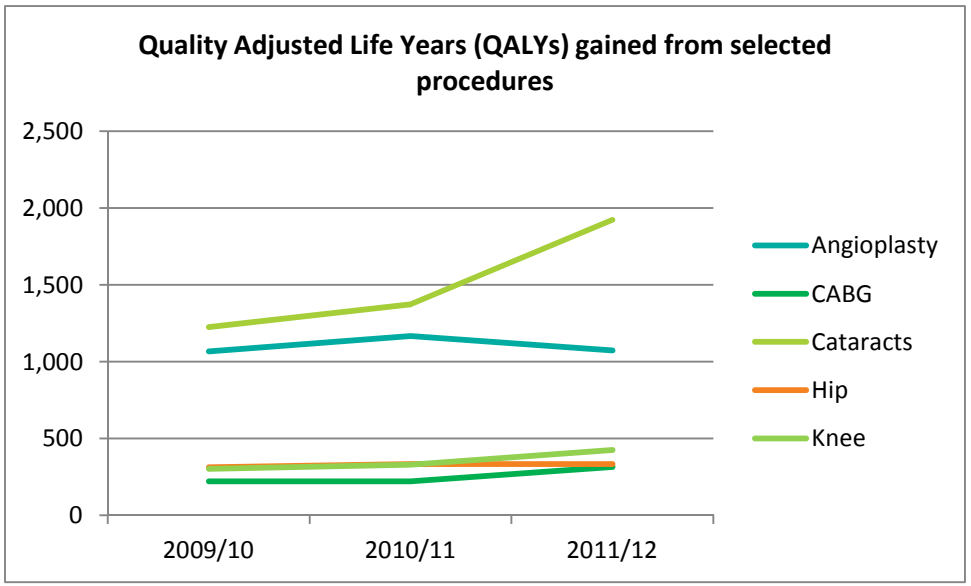
Trend graphs for selected output measures for elective services







Trend graph for elective services impact measure



Output: Assessment Treatment and Rehabilitation (Inpatient)

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults	Sub-acute inpatient care of older adults.	**Quantity** AT&R bed days	Bed-days are a standard measure of the total output from this activity	35,589	32,178	Ω	Ω	2011/12	Maximising functional independence and health-related quality of life in older adults **Impacts measured by** The proportion of patients with an improvement in function between AT&R admission and within 3 days of discharge as measured by the: • FIM (functional independence measure). (WDHB Only) • Barthel index (ADHB only)
		No. of AT&R inpatient events	A standard measure of the total output from this activity	1,926	1,826	Ω	Ω	2011/12	
		Quality In-hospital fractured neck of femur (FNOF) per 1000 admissions (age/sex standardised) – HQSC	A high quality AT&R service will rehabilitate their patients so that they fall less, this would indicate a high quality service	*New measure*	*New measure*	↓	↓		
		Timeliness Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	This is an indicator of the timeliness of our AT&R service	86%	52%	90%	90%		

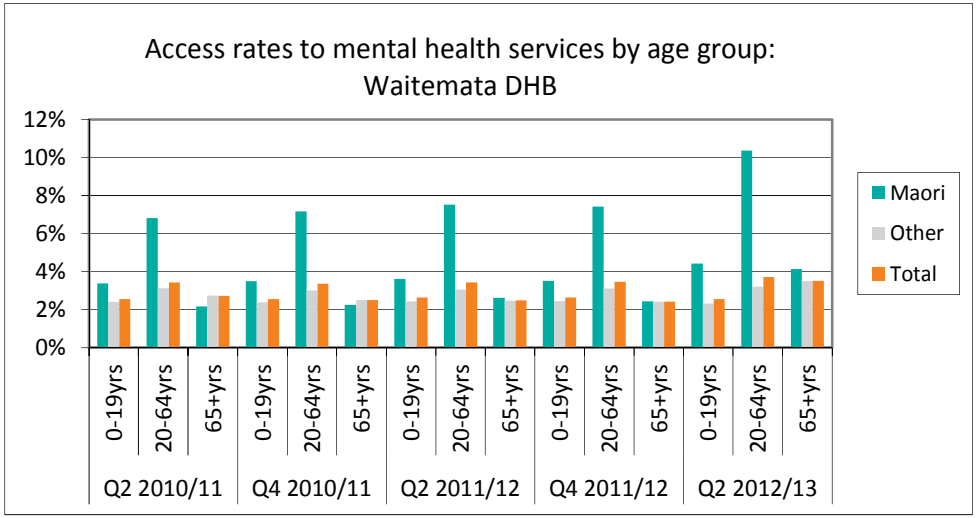
Output: Mental Health

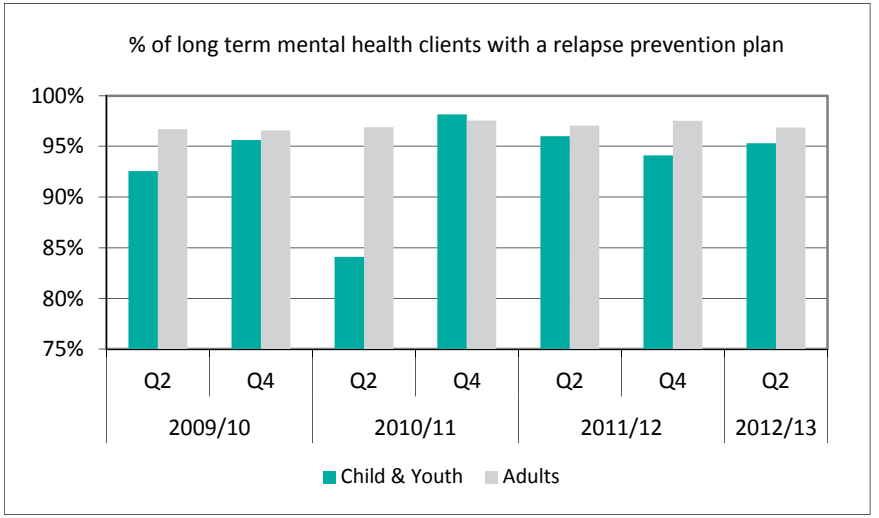
We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Age	Eth	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
						ADHB	WDHB	ADHB	WDHB		
Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands. The matrix of services comprise - Acute & Intensive services - Community based clinical treatment & therapy services - Services to promote resilience, recovery and connectedness.	**Quantity** Access Rates for total and specific population groups (defined as the proportion of the population utilising Mental Health and Addiction services in the last year). The population groups for which this indicator is measured are: • Total / child & youth / adult / older adult population (all ethnicities) • Māori (total / adult / child & youth / older adult)	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	0-19 20-64 65+	Māori Total Māori Total Total	4.42% 2.56% 10.36% 3.71% 3.52%	3.58% 2.66% 7.66% 3.45% 2.38%	2.53% 2.53% 3.3% 3.3%	3.58% 2.66% 7.66% 3.45%	As at Sep 2012	Prompt recovery from acute mental illness Prevention of mental illness relapses Social integration and improved quality of life **Impacts measured by** 28 day readmission rate☑
		Quality 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	Adult Child & Youth	Māori Pacific Other Māori Pacific Other	96% 99% 95% 100% 100% 91%	95.5% 99.37% 96.63% 100% 100% 92.12%	95% 95% 95% 95% 95% 95%	95% 95% 95% 95% 95% 95%	As at January 2013	

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Age	Eth	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
						ADHB	WDHB	ADHB	WDHB		
		Timeliness Shorter waits for non-urgent mental health and addiction services Seen within 3 weeks Seen within 8 weeks	Waiting times for service are an indicator of timeliness. Note: While the national DHB performance measures are 80% and 95%, interim targets are covered on page 120. These are broken down by type of service and by age band.			 60.8% 76.4%	 77.6% 86.2%	 80% 95%	 80% 95%	Apr 2011 – Mar 2012	

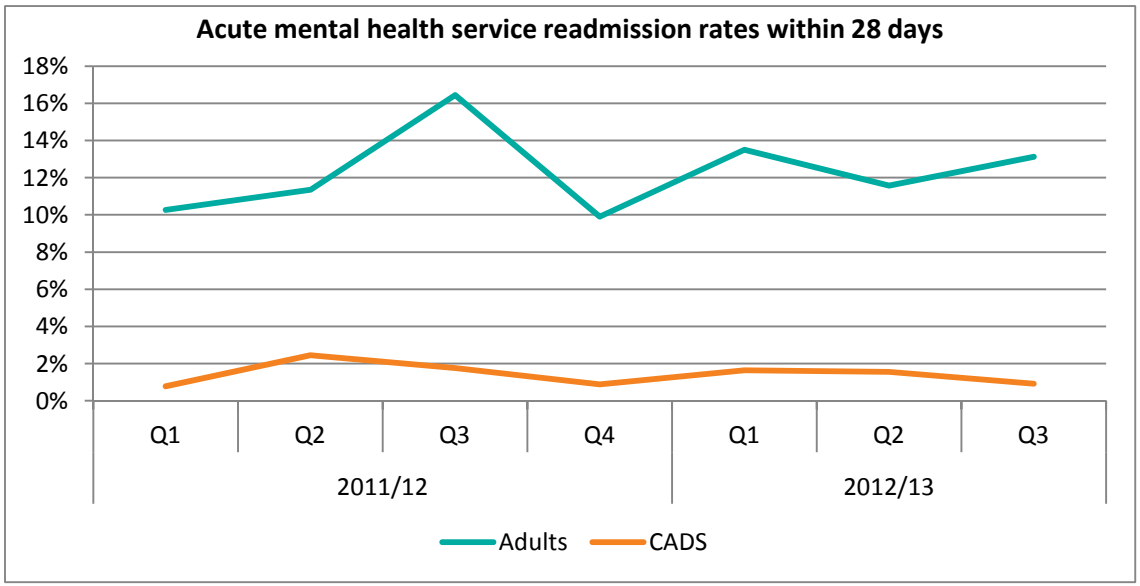
Ω Demand driven forecast activity

Trend graphs for selected output measures for mental health





Trend graph for mental health impact measure



Output Class 4: Rehabilitation and Support Services

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

Waitemata DHB aims 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, ameliorating ill health and relieving suffering. 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.

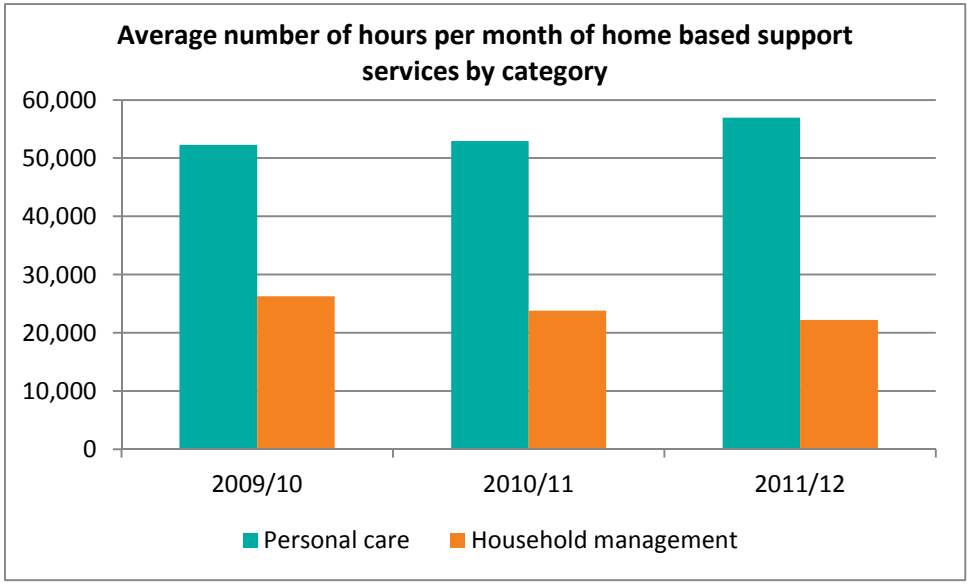
In addition to its contribution to health related quality of life, high quality and timely rehabilitation and support services provide patients with a positive experience and a sense of confidence and trust in the health system.

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	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Assess and plan the needs of older people for Home Based Support Fund home based support services delivered in accordance with assessed needs	Home based support assessments Home based support care	**Quantity** Average number of hours per month of home based support services for: • Personal care • Household management (WDHB only)		n/a	56,932 22,202	n/a		2011/12	Older people with complex needs remain living in their home for longer Better health and fewer accidents (eg falls) among people over 65 years Improved happiness and quality of life for older adults **Impacts measured by** Proportion of NASC referrals assessed to have high or very high needs who reside in their own home
		Total number of InterRAI assessments per month (ADHB only)	Simple indicator of output of service	400 per month	n/a	Ω	n/a	Average per month over 2011/12	
		Quality The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Good quality, comprehensive and regular assessments will reduce numbers going into residential care and, for older people, services in their own home are much more convenient	84%	38%	95%	65%	interRAI assessment **ADHB** 2012 calendar year **WDHB** Jul-Sep 12	
		Timeliness Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service	100%	88.9%	↑	↑	**ADHB** Based on average waiting time 2012 calendar year **WDHB** 2012 calendar year	

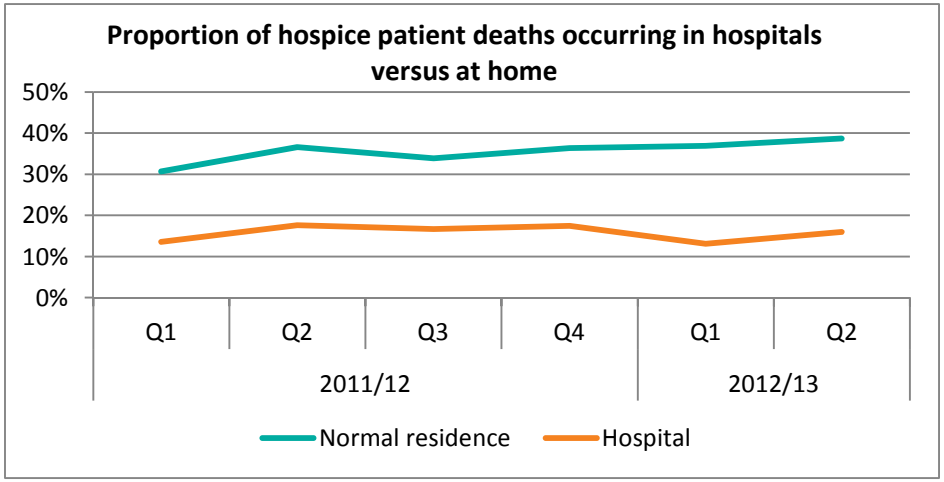
Trend graph for selected output measure for home based support services



Output: Palliative Care

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Contract or provide high quality generalist and specialist palliative care services	Hospice provided palliative care Specialist community palliative care services Home based palliative care services	**Quantity** Number of contacts (WDHB only)		n/a	21,418	n/a	Ω	2011/12	Improved quality of life for patients with life-threatening illness (and for their families/whānau) **Impacts measured by** Proportion of hospice patient deaths occurring in hospitals versus at home
		Total number of completed episodes of care (death or discharge) (ADHB only)	Inpatient hospice care is the main component off our expenditure on palliative care. Episodes or contacts measure the total output from this activity	911	n/a	Ω	n/a	2011/12	
		Quality Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline)	Indicator of access equality	**Admissions** M 5% P 11% A 12% **Deaths** M 7% P 10% A 8%	**Admissions** M 6% P 4% **Deaths** M 5% P 3%	% admitted should reflect % deaths by ethnicity	% admitted should reflect % deaths by ethnicity	Admissions = 2011/12 2010 cancer death data	
		Timeliness Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	Well functioning service should provide timely access for acute patients.	9.09%	18.44%	↓	↓	**WDHB** 2011/12 **ADHB**	

Trend graph for selected output measure for palliative care



Output: Residential Care

We will undertake these activities	And deliver these outputs	Outputs measured by	Rationale	Baseline		Target 2013/14		Baseline Info	That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB		
Ensure access to subsidised beds is based on assessed need Ensure sufficient contracted beds are available to people assessed as requiring long term residential care	Residential care bed days	**Quantity** Total number of subsidised aged residential care bed days	Bed days are a standard measure of the volume of aged residential care service.	984,651	803,220	Ω	Ω	2012	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 **Impacts measured by** Standardised acute admission rates from residential care
		Quality Proportion of aged care providers with 4 year audit certification	The granting of 4 year audit certification is a good indicator of ongoing confidence in the quality of care delivered by the facility.	8.82%	6.9%	↑	↑	As at 22 April 2013	
		Timeliness Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service	100%	88.9%	↑	↑	**ADHB** Based on average waiting time 2012 calendar year **WDHB** 2012 calendar year	

MODULE 5: Financial Performance

Financial Management Overview

Our new organisational values are embodied in our promise of "best care for everyone" to the community we serve. Critical to the long term ability to deliver on this promise is our commitment to remaining financially sustainable well into the future. This means that we have to continue to meet the growing demand for health service needs of our communities by ensuring that resources and infrastructure for service delivery are appropriately provided for within our means.

Our organisational financial goal is therefore to ensure that we continue to improve the health outcomes for our community in a financially sustainable manner. To achieve this, we are committed to continued development and implementation of strategies and initiatives to manage or curtail cost growth pressures facing the DHB in the face of slower funding growth for the DHB sector.

We will continue to:

- Embed our new values that recognise that "everyone matters", require us to be "connected" to our community and colleagues within the DHB and externally, across disciplines and sectors (primary/secondary interface) to ensure that we deliver quality, cost effective and patient focused services "with compassion". We will seek continuous improvement in our processes, policies, systems and procedures to ensure that our services get "better, best and brilliant" for the benefit of our communities
- Foster a culture of financial accountability and discipline underpinned by a Business Transformation programme that seeks to continuously identify and implement cost effectiveness strategies
- Identify and implement smarter ways of delivering quality health services more efficiently, more cost effectively and reducing any waste. We will do this in partnership with our Auckland DHB colleagues, also regionally through mechanisms such as healthAlliance and the Northern Region Alliance, and nationally through participation in processes such as national contract reviews and Health Benefits Limited (HBL) initiatives. We will deliver on national entity priorities that align with our agreed budget commitments (as outlined in our national priority initiative template).

Based on year to date financial performance and expectations for the rest of the 2012/13 financial year, and informed by robust organisational and financial analysis:

- We are forecasting a surplus of $6.8M for the 2012/13 year, against a planned surplus of $2M. This positive result reflects continued cost growth containment mostly in our funder arm services. Our Business Transformation programme has delivered savings in excess of $60M over the past two years, with savings of $12M planned for this financial year. As a result, the organisation has delivered surpluses in excess of $8M for the past two years and expecting an additional $6.8M this year.

  These surpluses have assisted in meeting the growing demand for capital investment to increase our capacity, refurbish our facilities, improve the quality of our services, reconfigure our services, invest in new technology and transfer services locally.

- Moving forward, 2013/14 will be a very financially challenging year for the DHB, probably the most challenging year so far, primarily due to the reduced funding growth. In prior years, our funding growth has exceeded $42M per year. However, 2013/14 is the first year where our funding growth (at $28.6M) is only slightly over half of that received in prior years. The challenge is how to continue to live within our means when we are faced with significant population growth, fast ageing population and high life expectancy, all of which are key drivers for health service demand growth.

- We are committed to contributing to our capital funding requirements and therefore, we are planning a surplus of $1M for each of 2013/14 and 2014/15 and, breakeven results for the 2015/16 year. We will work more with our collaboration partner (Auckland DHB), our neighbouring DHBs and sector wide (via Health Benefits Limited) for broader efficiencies and savings.

Key Assumptions for Financial Projections

Revenue Growth

Growth in Population Based Funding Formula (PBFF) revenue for 2013/14 is based on the National Health Board funding envelope advice, with an increase of $28.6M or 2.34 per cent over the 2012/13 funding envelope. This is comprised of a 0.89 per cent ($10.9M) increase to fund cost pressures and 1.45 per cent ($17.6M) for demographic growth.

For the out-years, we have assumed that the funding increase will be of the same nominal value as that signalled for 2013/14 by the National Health Board. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of $45M above the 2012/13 forecast level is planned and this is driven by demographic growth related cost pressure on services provided by the DHB, demographic growth impact on demand driven third party contracts, clinical staff volume growth to meet service growth requirements, costs for staff employment contract agreements and step increases, costs for national initiatives, cost of capital for new facility developments (interest, depreciation and capital charge) and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions include:

- Impact on Personnel Costs of all settled employment agreements, automatic step increases and new FTEs, risk provisions for expired employment contracts and of employment agreements expiring during the planning period
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of volume growth in services provided by the DHB plus impact of procurement cost savings as advised by healthAlliance
- Third party contracts have a planned increase in the price for Aged Care subsidies (0.89%) and for General Practice First Contact Services (1.00%). This is in line with the expectation documented in the Funding Envelope. Previously agreed price increases for 2013/14 will also be upheld including those agreed as part of sector wide processes (Community Pharmacy and Oral Health).
- The DHB is experiencing significant demand based utilisation growth in Aged Residential Care Private Hospital and Residential Dementia Services as well as in Aged Care Home Based Support Services. The related expenditure growth is in excess of associated demographic revenue and the shortfall will be recovered out of savings across other services.
- The DHB is also forecasting it will not be receiving an equitable share of the dispensing fee expenditure growth reduction resulting from the new Combined Pharmacy Service Agreement. The Community Pharmacy expenditure growth for the DHB is still forecast to be positive and in excess of the contribution to cost pressure adjustor and the associated demographic adjustor.

The Business Transformation initiative first implemented in 2010/11 is being used by the DHB to manage cost pressures by identifying savings to ensure the DHB lives within its means. The financial plan of a surplus of one million dollars is premised on achieving cost savings of $16.9M. The savings initiatives have been identified across the business and only the costs savings expected in the 2013/14 financial year have been included in the financial plan. Flow on savings annualised for the out years have been included in the out years. The strategies and savings initiatives to help us live within our means are described in Module 3 of the Annual Plan in the section titled "Living within our means". Brief descriptions of savings sources, savings amounts and timing of these are provided in the financial templates for the 2013/14 Annual Plan.

In planning for the surplus for 2013/14, we will be relying on savings initiatives that will be delivered through programs being undertaken by shared services (such as healthAlliance) and national agency entities (such as Health Benefits Limited, National Health IT Board etc).

Forecast Financial Statements

In line with requirements of Section 139(2) of the Crown Entities Act 2004, we provide both the Parent and Group Forecast Financial Statements. The Group represents the consolidated financial statements for Waitemata DHB, its subsidiaries and its interest in associates and jointly controlled entities. The Waitemata Group consists of the Parent, Waitemata DHB and Three Harbours Health Foundation.

The tables below provide a summary of the consolidated financial statements for the audited result for 2011/12, year-end forecast for 2012/13 and plans for 2013/14 to 2015/16.

Statement of Comprehensive Income – Parent

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Government and Crown Agency Revenue	1,269,258	1,319,550	1,359,251	1,390,242	1,421,245
Patient Sourced and Other Income	26,938	22,681	22,623	23,140	23,656
IDFs & Inter DHB Provider Income	78,345	77,504	75,624	77,351	79,078
Total Funding	**1,374,541**	**1,419,735**	**1,457,498**	**1,490,733**	**1,523,979**
Personnel Costs	477,224	499,054	516,778	528,564	540,352
Outsourced Costs	52,653	49,905	57,439	58,749	60,059
Clinical Supplies Costs	87,391	91,047	93,808	95,946	98,573
Infrastructure & Non-Clinical supplies Costs	96,817	98,659	96,782	99,010	101,753
Payments to Other Providers	655,447	672,785	691,691	707,464	723,242
Total Expenditure	**1,369,532**	**1,411,450**	**1,456,498**	**1,489,733**	**1,523,979**
Net Surplus / (Deficit)	**5,009**	**8,285**	**1,000**	**1,000**	**0**
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	(3,128)	(1,508)	0	0	0
TOTAL COMPREHENSIVE INCOME	**1,881**	**6,777**	**1,000**	1,000	**0**

Historically, the DHB has performed well financially, with surpluses generated in the past two years and a year-end forecast surplus also expected for this financial year. The business transformation programme implemented in 2010/11 has contributed significantly to achievement of the surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

Revenue continues to grow at a slower rate and, for 2013/14, this has presented a significant challenge for the DHB. However, we are committed to continuing to identify and implement savings strategies to bridge any funding gaps. For 2013/14 and 2014/15, we are also committed to generating a surplus of $1M in each year to contribute towards our capital programme.

Statement of Comprehensive Income - Group

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Government and Crown Agency Revenue	1,269,258	1,319,550	1,359,251	1,390,242	1,421,245
Patient Sourced and Other Income	27,550	23,331	23,273	23,790	24,306
IDFs & Inter DHB Provider Income	78,345	77,504	75,624	77,351	79,078
Total Funding	**1,375,153**	**1,420,385**	**1,458,148**	**1,491,383**	**1,524,629**
Personnel Costs	477,224	499,054	516,778	528,564	540,352
Outsourced Costs	52,653	49,905	57,439	58,749	60,059
Clinical Supplies Costs	87,391	91,047	93,808	95,946	98,573
Infrastructure & Non-Clinical supplies Costs	97,618	99,309	97,432	99,660	102,403
Payments to Other Providers	655,447	672,785	691,691	707,464	723,242
Total Expenditure	**1,370,333**	**1,412,100**	**1,457,148**	**1,490,383**	**1,524,629**
Net Surplus / (Deficit)	**4,820**	**8,285**	**1,000**	**1,000**	**0**
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	(3,128)	(1,508)	0	0	0
TOTAL COMPREHENSIVE INCOME	**1,692**	**6,777**	**1,000**	**1,000**	**0**

Statement of Cashflows - Parent

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Cashflow from operating activities					
MoH and other Government / Crown	1,365,002	1,397,054	1,434,875	1,467,593	1,500,323
Other Income	42,365	31,946	18,613	19,039	19,464
Interest received	3,119	4,661	4,010	4,101	4,192
Payments for Personnel	(464,699)	(499,054)	(516,778)	(528,564)	(540,352)
Payments for Supplies	(890,751)	(866,011)	(889,072)	(909,859)	(930,982)
Capital Charge Paid	(15,182)	(13,678)	(13,848)	(13,848)	(13,848)
GST Input Tax	(3,966)	(4,000)	(3,996)	(4,000)	(4,000)
Interest payments	(11,197)	(11,513)	(13,861)	(14,000)	(14,812)
Net cashflow from operating activities	**24,691**	**39,405**	**19,943**	**20,462**	**19,985**
Cashflow from investing activities					
Capital Expenditure (-ve)	(46,850)	(61,896)	(55,243)	(22,740)	(20,049)
Net cashflow from investing activities	**(46,850)**	**(61,896)**	**(55,243)**	**(22,740)**	**(20,049)**
Cashflow from financing activities					
Capital contributions from the Crown	5,190	0	0	0	0
Proceeds from borrowings	33,130	38,480	14,000	3,000	0
Repayment of borrowings	0	(500)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**38,320**	**37,980**	**13,000**	**2,000**	**(1,000)**
Net cash movements	**16,161**	**15,489**	**(22,300)**	**(278)**	**(1,064)**
Cash and cash equivalents at the start of the year	52,516	68,677	84,166	61,866	61,588
Cash and cash equivalents at the end of the year	**68,677**	**84,166**	**61,866**	**61,588**	**60,524**

Cashflow forecasts reflect the impact of major capital projects recently completed, under implementation or planned and these include the Lakeview Extension, Car Park, Oral Health, Elective Surgery Centre, Taharoto Mental Health Unit and Mason Clinic Remedial Works. DHB cash contribution is mainly from depreciation free cashflow, cash reserves accumulated over the past few years (including surpluses) and this is supplemented by Crown debt for projects approved by the Minister. Debt repayment for the Car Park project loan has been included in the plan.

All Waitemata DHB Crown debt secured through the Crown Health Financing Agency (CHFA) has been transferred to the National Health Board (following disestablishment of the CHFA). As at 1 May 2013, we have debt facility limits of $262.82M, of which $220.93M is drawn. The undrawn facilities are balances on the Lakeview Extension, Car Park and Elective Surgery Centre loan facilities. The total loan portfolio is expected to increase due to additional debt facilities for the Taharoto Mental Health Unit development.

Statement of Cashflows – Group

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Cashflow from operating activities					
MoH and other Government / Crown	1,365,002	1,397,054	1,434,875	1,467,593	1,500,323
Other Income	43,831	32,316	18,983	19,409	19,834
Interest received	3,465	4,941	4,290	4,381	4,472
Payments for Personnel	(464,699)	(499,054)	(516,778)	(528,564)	(540,352)
Payments for Supplies	(892,183)	(866,661)	(889,722)	(910,509)	(931,632)
Capital Charge Paid	(15,182)	(13,678)	(13,848)	(13,848)	(13,848)
GST Input Tax	(3,966)	(4,000)	(3,996)	(4,000)	(4,000)
Interest payments	(11,197)	(11,513)	(13,861)	(14,000)	(14,812)
Net cashflow from operating activities	**25,071**	**39,405**	**19,943**	**20,462**	**19,985**
Cashflow from investing activities					
Increase in Investments	403	0	0	0	0
Capital Expenditure (-ve)	(46,850)	(61,896)	(55,243)	(22,740)	(20,049)
Net cashflow from investing activities	**(46,447)**	**(61,896)**	**(55,243)**	**(22,740)**	**(20,049)**
Cashflow from financing activities					
Capital contributions from the Crown	5,190	0	0	0	0
Proceeds from borrowings	33,130	38,480	14,000	3,000	0
Repayment of borrowings	0	(500)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**38,320**	**37,980**	**13,000**	**2,000**	**(1,000)**
Net cash movements	**16,944**	**15,489**	**(22,300)**	**(278)**	**(1,064)**
Cash and cash equivalents at the start of the year	52,529	69,473	84,962	62,662	62,384
Cash and cash equivalents at the end of the year	**69,473**	**84,962**	**62,662**	**62,384**	**61,320**

Statement of Financial Position - Parent

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Current Assets	99,987	116,506	95,809	96,410	95,732
Non-current assets	476,339	505,197	543,549	545,271	547,292
Total assets	**576,326**	**621,703**	**639,358**	**641,681**	**643,024**
Current Liabilities	267,700	267,983	270,222	268,742	270,950
Non-current liabilities	141,861	180,178	194,594	197,397	196,532
Total liabilities	**409,561**	**448,161**	**464,816**	**466,139**	**467,482**
Net assets	**166,765**	**173,542**	**174,542**	**175,542**	**175,542**

Total equity	**166,765**	**173,542**	**174,542**	**175,542**	**175,542**

A strong asset base is indicated, with total assets planned at $622M by 2012/13 year end reflecting completed capital projects. A full revaluation of assets was undertaken at 30 June 2012 and this resulted in a reduction in land and building asset values of $3.1M.

Statement of Financial Position - Group

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Current Assets	101,942	118,506	97,809	98,410	97,732
Non-current assets	480,187	509,197	547,549	549,271	551,292
Total assets	**582,129**	**627,703**	**645,358**	**647,681**	**649,024**
Current Liabilities	267,676	267,983	270,222	268,742	270,950
Non-current liabilities	141,861	180,178	194,594	197,397	196,532
Total liabilities	**409,537**	**448,161**	**464,816**	**466,139**	**467,482**
Net assets	**172,592**	**179,542**	**180,542**	**181,542**	**181,542**

Total equity	**172,592**	**179,542**	**180,542**	**181,542**	**181,542**

Disposal of Land

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

Statement of Movement in Equity – Parent

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Balance at 1 July	**159,693**	**166,765**	**173,542**	**174,542**	**175,542**
Comprehensive Income/(Expense)					
Surplus / (deficit) for the year	5,009	8,285	1,000	1,000	0
Other Comprehensive income	(3,128)	(1,508)	0	0	0
Total Comprehensive Income	**1,881**	**6,777**	**1,000**	**1,000**	**0**
Owner transactions					
Capital contributions from the Crown	5,191	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0
Balance at 30 June	**166,765**	**173,542**	**174,542**	**175,542**	**175,542**

The shareholder's equity position improved due to the surpluses generated in prior years and expected for 2012/13 through to 2014/15. This is reduced by downward revaluation movements in building/land assets reflected in Other Comprehensive Income.

Statement of Movement in Equity - Group

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Balance at 1 July	**165,709**	**172,592**	**179,369**	**180,369**	**181,369**
Comprehensive Income/(Expense)					
Surplus / (deficit) for the year	4,820	8,285	1,000	1,000	0
Other Comprehensive income	(3,128)	(1,508)	0	0	0
Total Comprehensive Income	**1,692**	**6,777**	**1,000**	**1,000**	**0**
Owner transactions					
Capital contributions from the Crown	5,191	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0
Balance at 30 June	**172,592**	**179,369**	**180,369**	**181,369**	**181,369**

Additional Information

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

Provider Arm Financial Performance

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Income					
MoH via Funder	623,112	650,681	681,438	696,975	712,518
MoH Direct	36,305	37,213	37,511	38,366	39,222
Other	39,810	35,124	37,231	38,082	38,932
Total Income	**699,227**	**723,018**	**756,180**	**773,423**	**790,672**
Expenditure					
Personnel	472,055	493,536	510,766	522,414	534,064
Outsourced services	49,785	46,745	54,537	55,781	57,025
Clinical supplies	87,391	91,047	93,808	95,946	98,573
Infrastructure & non clinical supplies	95,279	97,005	96,069	98,282	101,010
Total expenditure	**704,510**	**728,333**	**755,180**	**772,423**	**790,672**
Surplus / (Deficit)	**(5,283)**	**(5,315)**	**1,000**	**1,000**	**0**
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	**(3,128)**	**(1,508)**	**0**	**0**	**0**
Total Comprehensive Income	(8,411)	(6,823)	1,000	1,000	0

An operating deficit of $5.3M was realised in 2011/12 and an operating deficit of $5.3M is also forecast for the 2012/13 year end (against a planned surplus of $1M). These deficits reflect cost pressures from a combination of volume growth and price factors for provider arm services. The provider arm has achieved some savings in prior years. However, some of these savings have not

been sustainable and overall have not been sufficient to fully offset provider arm cost growth pressures. When including the losses on WDHB land and building asset revaluations, the Provider arm deficit is $8.4M for 2011/12 and $6.8M for 2012/13.

68% of provider arm costs are in personnel (employed and outsourced staff) and the balance are in clinical/non clinical supplies, infrastructure (including financing costs) and outsourced services. Productivity improvements, efficiencies and cost effective operating models are being explored to enable the provider arm to live within its means. The Elective Surgery Centre is expected to introduce a highly productive and cost effective service model for elective surgery and, other initiatives including primary care integration are being pursued. Collaboration with Auckland DHB is a key initiative for service reconfiguration efficiencies.

For 2012/13, the provider arm forecast deficit is expected to be fully offset by the funder arm surpluses, resulting in an overall surplus for the entire DHB.

For 2013/14, the Provider arm surplus planned is expected to be achieved after realising savings and efficiencies of $16.9M, including savings initiatives to be delivered by shared services and national agency entities such as healthAlliance and Health benefits Limited.

The DHB is also committed to a surplus of $1M for the 2014/15 year.

Governance and Funding Administration Arm Financial Performance

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Revenue	10,681	10,332	9,627	9,846	10,065
Expenditure	9,575	10,332	9,627	9,846	10,065
Surplus/(Deficit)	**1,106**	**0**	**0**	**0**	**0**

The governance and funding administration arm continues to perform within the funding allocated, with a surplus achieved in 2011/12 and breakeven expected in the forecast and planning period.

The decrease in revenue and expenditure in 2013/14 reflects the transfer of Governance related costs to Corporate to reflect changes in the current reporting structure and reflective of a part component of the new collaborative structure with Auckland DHB (which is still work in progress at this time). It is expected that revenue and expenditure will continue to change and these changes will remain neutral to the core result.

Funding Arm Financial Performance

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Revenue	**1,298,588**	**1,347,046**	**1,382,007**	**1,413,519**	**1,445,042**
Expenditure					
Personal Health	937,303	968,926	1,015,842	1,039,007	1,062,180
Mental Health	196,462	198,382	199,362	203,908	208,455
DSS	139,954	149,989	147,448	150,809	154,172
Public Health	3,095	4,322	8,809	9,009	9,209
Maori Health	1,745	1,847	1,668	1,706	1,744
Governance	10,843	9,980	8,878	9,080	9,282
Total Expenditure	**1,289,402**	**1,333,446**	**1,382,007**	**1,413,519**	**1,445,042**
Surplus/(Deficit)	**9,186**	**13,600**	**0**	**0**	**0**

The funder generated a surplus of $9.2M in 2011/12 and is forecasting a year end surplus of $13.6M for 2012/13. The funder forecast includes inter district flow services and third party provider services (non-government organisations) and the surplus represents a favourable position to budget across both these service categories. This notwithstanding, the funder is facing significant cost growth pressures in aged care and community pharmacy services and to a lesser extent also in primary care services and oral health services. These services form a substantial component of the funder budget and accommodating the associated funding requirement is expected to be a challenge moving forward. The funder is planning for a breakeven position for the future planning period.

Capital Expenditure

	2011/12 Audited $000	2012/13 Forecast $000	2013/14 Plan $000	2014/15 Plan $000	2015/16 Plan $000
Funding Sources:					
Free cashflow from depreciation	21,322	20,719	22,665	23,182	23,699
External Funding	38,320	38,480	14,000	3,000	0
Cash reserves	13,215	34,292	32,595	14,017	17,459
Total Funding	**72,857**	**93,491**	**69,260**	**40,199**	**41,158**
Baseline Capital Expenditure					
Land	0	0	0	0	0
Buildings & Plant	(4,776)	(5,020)	(9,472)	(3,000)	(5,000)
Clinical Equipment	(3,571)	(3,500)	(4,500)	(3,000)	(8,000)
Other Equipment	(888)	(1,714)	(205)	(500)	(600)
Information Technology	(1,641)	(430)	(600)	0	0
Intangible Assets (Software)	0	(1,250)	0	0	0
Motor Vehicles	(326)	(1,000)	0	(700)	(1,000)
Total Baseline Capital Expenditure	**(11,202)**	**(12,914)**	**(14,777)**	**(7,200)**	**(14,600)**
Strategic Investments					
Land	0	0	0	0	0
Buildings & Plant	(29,970)	(31,832)	(29,101)	(12,814)	(2,949)
Clinical Equipment	(3,816)	(11,808)	(1,500)	0	0
Other Equipment	0	0	0	0	0
Information Technology	0	(350)	(2,810)	(625)	(625)
Intangible Assets (Software)	0	(3,129)	(7,055)	(2,101)	(1,875)
Motor Vehicles	(1,863)	(1,863)	0	0	0
Total Strategic Capital Expenditure	**(35,648)**	**(48,982)**	**(40,466)**	**(15,540)**	**(5,449)**
Total Capital Payments	**(46,850)**	**(61,896)**	**(55,243)**	**(22,740)**	**(20,049)**

Major capital projects included in the strategic capital expenditure summarised above include:

- Lakeview Extension: Project completed on time and within the approved budget of $53.7M.
- Car Park: Project completed on time and within the approved budget of $24.544M.
- Oral Health Project: Project to be completed this year, slightly over the approved budget of $13.8M.
- Elective Surgery Centre: Project to be completed on time, by this year end and within the approved budget of $39.4M. The unit will be operational from 1 July 2013.
- Taharoto Mental Health Unit: Project has an approved budget of $25M and will take three years to complete.
- Mason Clinic Remedial Works: Project has an approved budget of $9.9M and will take four to five years to complete.

Banking Facilities and Covenants

Term Debt Facilities

Waitemata DHB has term debt facilities of $262.8M with the National Health Board, of which $220.9M is currently drawn. The Debt portfolio will increase by $15M to $277.8M due to new Crown debt to finance the Taharoto Mental Health Unit.

Working Capital Facilities

Working capital facilities of $40M with private sector banks were cancelled as these are no longer required under the new shared banking facilities for DHBs negotiated by HBL.

Shared Commercial Banking Services

Waitemata is in the shared commercial banking arrangements with various other DHBs, Westpac and Health Benefits Limited.

Banking Covenants

Standard financial covenants put in place by CHFA are currently waived.

MODULE 6: Appendices

Statement of accounting policies for the year ending 30 June 2014

REPORTING ENTITY

The Waitemata District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of WDHB comprise WDHB and its subsidiaries (together referred to as "Group") and WDHB's interest in associates and jointly controlled entities. The WDHB group consists of the parent, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board), joint ventures are healthAlliance N.Z. Limited (20%), Health Innovation Hub Limited (25%), Awhina Health Campus and associate companies are Northern Regional Training Hub Ltd (33%) (formerly Auckland Regional RMO Service Limited) and Northern DHB Support Agency (34%).

The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

Waitemata DHB's Corporate Address is:

Level 2, 15 Shea Terrace
Takapuna
AUCKLAND 1332

BASIS OF PREPARATION

Statement of compliance

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

The financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land, and buildings.

Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its subsidiary, associates and joint ventures is New Zealand dollars (NZ$).

Changes in accounting policies

There have been no changes in accounting policies during the financial year.

Early adopted amendments to standards
The following amendments to standards have been early adopted:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the DHB is that certain information about property valuations is no longer required to be disclosed.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted
NZ IFRS standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB, are:

NZ IFRS 9 *Financial Instruments will* eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Compliance with the Crown Entities Act
Section 139(2) of the Crown Entities Act 2004 requires WDHB in its Statement of Intent to include two forecast financial statements, the first for the parent and the second for the group. The 2013/14 Statement of Intent provides both the Parent and Group Forecast Financial Statements.

SIGNIFICANT ACCOUNTING POLICIES

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

The DHB does not consolidate its subsidiary Milford Secure Properties as it is dormant and is not material.

Joint ventures
A joint venture is a contractual arrangement whereby two or more parties undertake an economic activity that is subject to joint control.

Waitemata DHB is party to three joint ventures arrangements. One is a jointly controlled operation; Awhina Health Campus. The DHB recognises in its financial statements the assets it controls, the revenue that it earns, the liabilities and expenses that it incurs from this joint operation.

healthAlliance N.Z. Limited is a joint venture company with Health Benefits Limited, Counties Manaukau, Auckland and Northland DHBs that exists to provide a shared services agency to the four Northern DHBs in respect to information technology, procurement and financial processing.

The third joint venture is Health Innovation Hub Limited. The four largest District Health Boards (Waitemata, Counties Manaukau, Auckland and Canterbury) have established a national Health Innovation Hub. The Hub will engage with the DHBs, clinicians and industry to collaboratively realise and commercialise products and services that can make a material impact on health care in NZ and internationally. The Hub has been structured as a limited partnership, with the four foundation DHBs each having 25% shareholding in the limited partnership and the general partner, NZ Health innovation Hub Management Limited.

Associate
An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. The interests in Northern DHB Support Agency and Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited) are not accounted for as they are not material to Waitemata District Health Board.

Revenue
Revenue is measured at the fair value of consideration received or receivable.

MOH revenue
The DHB is primarily funded through revenue received from the MoH, which is restricted in its use for the purpose of the DHB meeting its objectives.

Revenue from the MoH is recognised as revenue when earned.

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

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

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

Rental income
Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of services
Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date.

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

Expenses

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

Interest expense
The DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases
Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

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

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

Bank overdrafts are shown within borrowings in current liabilities in the statement of financial position.

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

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.

Debtors and other receivables
Debtors and other receivables are recorded at their face value, less any provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments
Bank deposits
Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories
Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale
Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

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

- land;
- buildings;
- clinical equipment;
- IT equipment; and
- other equipment and motor vehicles.

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

Revaluations
Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

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

Additions
The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

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

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

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

Buildings (including components) 6 to 60 years (1.67%-16.67%)
Clinical equipment 3 to 20 years (5%-33%)
Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
IT Equipment 5 to 15 years (6.67%-20%)

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets
Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

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

Impairment of property, plant, and equipment and intangible assets
Property, plant, and equipment and intangible assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the

amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables
Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

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

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

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

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

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements
Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes
Defined contribution schemes
Employer contributions to KiwiSaver, the Government Superannuation Fund, and the State Sector Retirement.

Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

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

Provisions are not recognised for future operating losses.

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme
The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years up to a specified maximum amount. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

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

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

- Crown equity;
- accumulated surpluses;
- revaluation reserves; and
- trust funds.

Revaluation reserves
These reserves are related to the revaluation of land and buildings to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to Three Harbours Health Foundation.

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

Budget figures
The budget figures are per the Waitemata DHB 2013/14 District Annual Plan. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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

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

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

The cost allocation methodology is currently under review. It is possible that the methodology may be modified from that applied to the last audited financial statements.

Glossary

APGAR	System of assessing the general physical condition of a newborn infant
ARPHS	Auckland Regional Public Health Service
AT&R	Assessment, Treatment and Rehabiliatation
ASH	Ambulatory Sensitive Hospitalisations
BSA	Breast Screen Aotearoa
CABG	Coronary artery bypass graft
CPO	Controlled Purchase Operation
CT	Computerised Tomography
CVD	Cardiovascular disease
DHB	District Health Board
DMFT	Decayed, missing or filled teeth
ED	Emergency Department
ENT	Ear, Nose and Throat
ESPI	Elective Services Performance Indicators
FSA	First Specialist Assessment (outpatients)
FTE	Full Time Equivalent
GAIHN	Greater Auckland Integrated Health Network
GMS	General Medical Subsidy
GP	General Practitioner
HbA1c	Glycosylated haemoglobin level - measures average blood glucose over time
HBL	Health Benefits Limited
HQSC	Health Quality and Safety Commission
IDF	Inter-district flow – movement of patients between DHBs
iFOBT	Immunochemical faecal occult blood test
InterRAI	Internationally used tool for assessing the medical, rehabilitation and support requirements of the older person
LMC	Lead Maternity Carer
Manawhenua	Iwi of the region with Trusteeship of Land
MoH	Ministry of Health
MOU	Memorandum of Understanding
MRI	Magnetic resonance imaging - scan
MUR	Medicine Use Reviews
NASC	Needs assessment and Service Coordination
NGO	Non-government Organisation
NHB	National Health Board
NHI	National Health Index (patient's health index number)
NICU	Neonatal Intensive Care
NRA	Northern Region Alliance (NoRTH and Northern Region DHB support Agency)
NRHP	Northern Regional Health Plan
PAS	Patient Administration System
PCI	Percutaneous coronary intervention eg. stent, angioplasty
PHO	Primary Healthcare Organisation
Q1 Q2 Q3 Q4	Quarters 1-4, ie by 30 September, 31 December. 31 March or 30 June
QALY	Quality Adjusted Life Years
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention.
WCTO	Well Child / Tamariki Ora
Whānau	Extended family
Whānau Ora	Families supported to achieve their maximum health and wellbeing
WIES	Weighted Inlier Equivalent Separation (weighting applied to inpatient discharges)
YTD	Year To Date

Waitemata
District Health Board

Best Care for Everyone

Classification number: (Review date:)