AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

2016/17 Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Auckland District Health Board

Mihimihi

E nga mana, e nga reo, e nga karangarangatanga tangata
Ko te Toka Tu Mai O Tamaki Makaurau tenei
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa
Ki wa tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, 'Oranga Tika', mo te 'Te Toka Tu Mai' mo te iti me te rahi
Hei huarahi puta hei hapai tahi mo tatou katoa
Hei Oranga mo te Katoa
No reira tena koutou, tena koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities
This is the message from the Auckland District Health Board
We send greetings to you all
We acknowledge the spirituality and wisdom of those who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to ensure a healthy tomorrow; greetings
This is the Annual Plan of the Auckland District Health Board
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

"Kaua e mahue tetahi atu ki waho
Te Tihi Oranga O Ngati Whatua"

Auckland District Health Board Annual Plan 2016/17

The Auckland District Health Board Annual Plan for 2016/17 is signed for and on behalf of:

Auckland District Health Board

Dr Lester Levy, CNZM
Chairman

Dr Lee Mathias, ONZM
Deputy Chairman

Ailsa Claire
Chief Executive

Our Te Tiriti o Waitangi partners
Te Runanga o Ngati Whatua

R Naida Glavish, JP ONZM
Chair, Te Runanga o Ngati Whatua

And signed on behalf of:

The Crown

25/10/16.

Hon Dr Jonathan Coleman
Minister of Health

Date

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

27 OCT 2016

Dr Lester Levy
Chairperson
Auckland District Health Board
Private Bag 92189
Auckland Mail Centre
Auckland 1142

lester.levy@waitematadhb.govt.nz

Dear Dr Levy

Auckland District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed Auckland District Health Board's (DHB's) 2016/17 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Auckland DHB has committed to implement a new after-hours service, develop an implementation plan for service improvements on Waiheke Island, and review and then improve primary options for acute care services. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change

that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Ms Ailsa Claire OBE
Chief Executive
Auckland District Health Board
Private Bag 92189
Auckland Mail Centre
Auckland 1142

ailsac@adhb.govt.nz

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MODULE 1: Introduction and Strategic Intentions (Statement of Intent)

The Statement of Intent covers the four-year period: 1 July 2016 to 30 June 2020.

Foreword from the Chair and Chief Executive

Auckland District Health Board (DHB) works hard to support our local population to maximise health outcomes, to fund and provide the best health and disability services possible, to contribute our skills for the benefit of the health and disability sector as a whole, and to do this all whilst living within our means. We are working more, not just with partners in health, but also across the social sector to ensure we collectively support Aucklanders to maximise their health and wellbeing.

We aspire to support our local communities, family and whānau to achieve the health outcomes they want for themselves. This focus on people, as reflected in both our values and patient-centric model, is one of seven key strategic themes for Auckland DHB. This approach impacts on all we do, from making health information easier to access, to web-based applications that allow patients to manage aspects of their healthcare online, to our approach to patient safety in making sure our systems enable staff to focus on the things that matter to each patient.

We want to develop a deeper understanding of what is important to people, and what support they would like from us. This is especially important in localities. By working with providers, community leaders and service users, we learn how to provide services in a way that is more physically and culturally accessible for residents of a defined geographical area. Service users and others are engaged in the co-design and evaluation of these services.

Some groups in our district face real hardship and these are the groups we see in hospital most often. All people living in our Auckland district should have an equal opportunity to live a long, healthy life, regardless of income, education, ethnicity or where they live. Prioritising projects, programmes and funding means we can more purposefully direct our DHB resources to the groups with the greatest need.

In 2016/17, we will configure services so people find it easier to navigate from one service to the other; we will collect better data and use it to inform our decision making, and we will be more flexible in how we do our work, always seeing the bigger picture. Over the long term, we know we can reduce some of the demand on hospital services by prevention work done with, and for, our communities, especially if the work is empowering and builds on strengths.

Another strategic theme commits us to operational and financial sustainability. In addition to our services for the Auckland DHB population, we provide a significant number of national and tertiary services and are by far the biggest provider in New Zealand of this range of services. These national and tertiary services are complex, the volumes are not always easily predictable and they require very significant resources and therefore present financial challenges. Independent of this, all of our DHB activities must be provided within budget, while guaranteeing safety, quality and the best outcomes possible. This requires us to manage the treatment, research and medical training we do for other DHBs, ensuring that the work is done within scope and cost so we do not draw on funding earmarked for our local population.

We are a large organisation with a large impact on the Auckland environment. Our waste minimisation work and work to reduce staff and patients' use of cars for transport are examples of how, as a public entity and one of the largest employers in the country, we aim to use resources prudently and to reduce our environmental impact, now and for future generations.

Now that our strategic themes are in place, we look forward to working with renewed energy on the things that matter most. This work occurs across the whole DHB system, our many community providers, NGOs, PHOs, volunteer and support groups, and of course the hospital and its related community services. We greatly appreciate your hard work, your commitment and importantly your care and concern for our patients, their family, whānau and also each other.

Dr Lester Levy, CNZM
Chairman
Auckland District Health Board

Ailsa Claire, OBE
Chief Executive
Auckland District Health Board

Te Tiriti o Waitangi

Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. In doing so, we commit to the intent of Te Tiriti o Waitangi that established Iwi as equal partners alongside the Crown, with the Articles of Te Tiriti providing the strong foundation upon which our nation was built.

Within a health context, the four Articles of Te Tiriti provide a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, that is responsive to the needs and aspirations of Māori communities, and achieves equitable health outcomes for Māori and other vulnerable members of our communities. We recognise the importance of our Memoranda of Understanding (MOU) partner Te Rūnanga o Ngāti Whātua in the planning and provision of healthcare services in order to achieve this system and Māori health gain.

Article 1 – Kawanatanga (governance) equates to health systems performance. It covers the structures and systems that are necessary to facilitate Māori health gain and reduce inequalities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is concerned with opportunities for Māori leadership, engagement, and participation in relation to the 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 inequalities in the 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.

In practice, Te Tiriti o Waitangi is fully expressed in Whānau Ora.

Whānau ora

Whānau Ora, in the context of this plan, is concerned with an intra- and intersectorial strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing. 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.

About Auckland DHB

Who we are and what we do

The Auckland District Health Board (DHB) is one of 20 DHBs established under the Health and Disability Act 2000. Auckland DHB is the Government's funder and provider of health services to the 510,500 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier. The boundaries of Auckland DHB extend to the Auckland Harbour Bridge in the north, Blockhouse Bay in the west and to Otahuhu in the southeast.

Did you know? **We are the fourth largest and one of the fastest growing DHBs in New Zealand. Auckland has over 510,500 residents and we expect population growth of 16% (82,000 more people) by 2025**

The objectives of DHBs are outlined within the Health and Disability Act 2000. These objectives include:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support.

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets. Our Planning, Funding and Outcomes Division is responsible for assessing its population's health need and determining the mix and range of services to be purchased within the available funding and specific financial constraints. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus within our district. The identified needs are then balanced alongside national and regional priorities. These processes inform the Northern Region Health Plan, which sets the longer-term priorities for DHBs in the northern region, this Annual Plan and the Auckland DHB's Māori Health Plan.

Did you know? **Over 100,000 people were seen in our Emergency Departments in 2014/15 and we performed 13,900 elective surgical procedures**

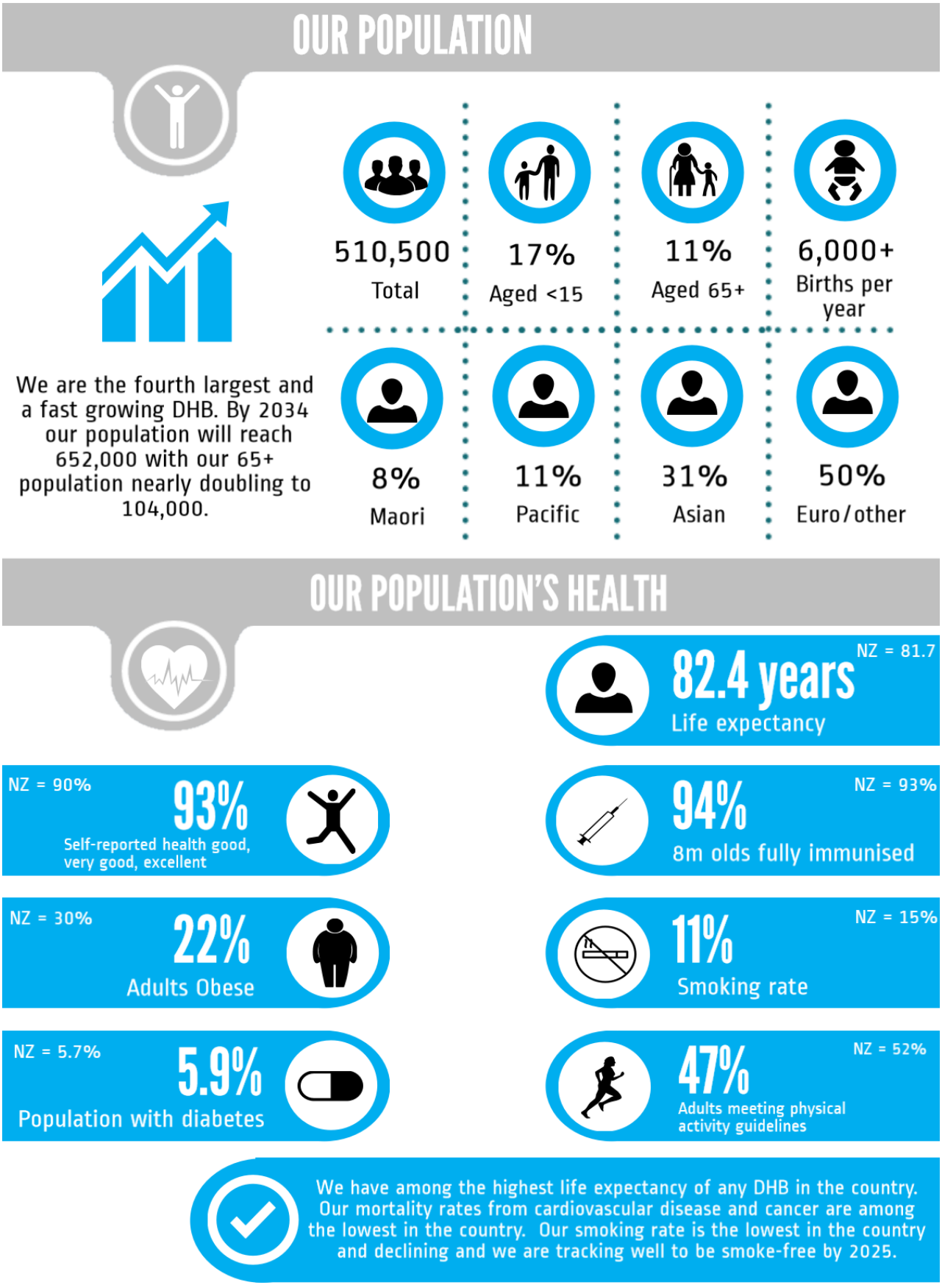
Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. Other services we provide include community child and adolescent health and disability services, community mental health services and district nursing. There are also 138 GP practices within the district and 130 pharmacies. We contract with 68 residential care homes offering 3,500 beds and invest $101M in community mental health and addiction services. Every year 16,667 preschool and school aged children are seen at dental clinics and 2.8 million community laboratory tests are completed.

Did you know? **We are the largest trainer of doctors in New Zealand, and a national leader in clinical research, with over 1,100 research projects undertaken in 2012–14**

Auckland DHB is unique in that we provide specialist services not available within other DHBs. We are a specialist provider of services, including organ transplant services (heart, lung and liver), specialist paediatric services, epilepsy services and high risk obstetrics. We are a major academic facility and carry a large training and research role for the country.

Did you know? **Our budget in 2016/17 is $2.1 billion**

Population Profile



Our Achievements

WE ARE HEALTHY

We are one of the healthiest communities in New Zealand and our life expectancy is higher than the New Zealand average. Our mortality rates from cardiovascular disease (CVD) and cancer are among the lowest in New Zealand, and our five-year cancer survival rates are among the highest

Life expectancy – 82.4 years (2014)
CVD mortality – 102/100,000 (NZ = 106)
Cancer mortality – 111/100,000 (NZ = 124)
Smoking rate – 11%
Cancer survival (5 year) – 65.6%

OUR CHILDREN GET A GREAT START

Children in our district are getting the best start to life. We have a very low infant mortality rate and highly successful health promotion and prevention programmes

Infant mortality – 4.5/1,000
Immunisation at 8 months – 94%
Immunisation at 24 months – 95%
B4SC rate – 96%

WE ARE TACKLING INEQUALITIES

Life expectancy among our Māori and Pacific population is increasing. Immunisation coverage and cancer screening rates among Māori and Pacific are improving, with Pacific breast screening rates above the overall rate for the DHB

Māori life expectancy – 79.4 years
Pacific life expectancy – 77.4 years
Cervical screening: Māori – 58.5%
Cervical screening: Pacific – 81.9%
Breast screening: Māori – 60.3%
Breast screening: Pacific –75.9%

WE PROVIDE RAPID ACCESS TO HIGH QUALITY CARE

Our hospitals are providing safe, high quality and compassionate care. We achieved excellent results across the Health Quality and Safety Commission (HQSC) markers and are meeting our Emergency Department and Elective Services waiting times targets

HQSC markers:
Falls risk assessment – 92%
Hand hygiene – 81%
Antibiotic given pre-surgery – 96%

WE ARE LIVING WITHIN OUR MEANS

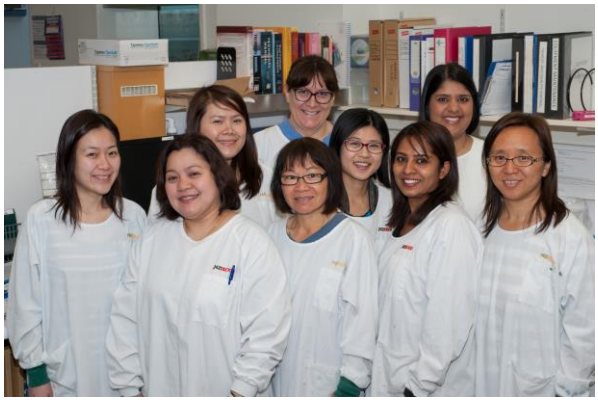
We have lived within our means for the past five years and are forecasting a surplus in 2015/16. We have continued to invest in growing our frontline staffing numbers to keep up with demand while creating efficiencies and business transformation have resulted in savings

$2.4M surplus forecast in 2015/16
Clinical FTE increased 31% since 2009

WE ARE LEADERS IN CLINICAL RESEARCH

We are the largest clinical research facility in New Zealand

Research portfolio comprises over 1,100 projects



The key challenges we are facing

Over the next ten years:

- **Growing and aging population** – the population will increase to approximately 652,000 by 2034 and the 65+ population will double over the next 20 years; combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around 45% of beds)
- **Prevention and management of long-term conditions** – the most common causes of death are cardiovascular disease (29%), cancer (28%) and respiratory disease (8%); a large proportion of these is avoidable (26%, or 620 deaths)
- **Health inequalities** – particular populations in our catchment continue to experience inequalities in health outcomes. This is most starkly illustrated by the gap in life expectancy of 5.2 years for Māori and 6.5 years for Pacific compared with other ethnicities
- **Patient-centred care** – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it
- **One system** – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services
- **Financial sustainability** – the financial challenge facing the broader health sector and Auckland DHB is substantial, with the current trajectory of cost growth estimated to outweigh revenue growth by 2025.

Given the aforementioned challenges, we have identified the following risks as being relevant for 2016/17, as well as opportunities that will enable us to address these challenges.

Risks	Mitigations/opportunities
Ensuring long-term sustainability through fiscal responsibility	• Effective governance and strong clinical leadership • Connecting the health system and working as one system • Delivering the best evidence-based care to avoid wastage • Ensuring tight cost control to limit the rate of cost growth pressure
Changing population demographics	• Engaging patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs • Assisting people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals, and increasing our focus on proven preventative measures and earlier intervention
Meeting future health needs and the growing demand for health services	Maintaining momentum in key areas, such as: • Continued focus on upstream interventions to improve the social and economic determinants of health, within and outside of the health system • Providing evidence-based management of long-term conditions • Working as a whole system to better meet people's needs • Working regionally and across the Government and other services to address health and other priorities • A relentless focus on quality improvement in all areas • Ongoing development of services, staff and infrastructure • Involving patients and family in their care.

Health and Safety

The health and safety of staff, patients and others utilising our facilities and services is paramount. Our health, safety and wellbeing aspiration is expressed in the Auckland DHB Health and Safety Board Charter:

A safe environment for everyone. A culture of excellence in health and safety performance.

More detail on this and our work-plan for the coming year to increase our level of leadership, commitment and performance can be found in Module 5.

Our direction – a strategy to 2020

Healthy Communities, World-class Healthcare, Achieved Together

Kia kotahi te oranga mo te iti me te rahi o te hāpori

Our vision recognises that each individual has different experiences and aspirations for health and wellbeing. Our job is to help people achieve the outcomes that matter to them, to their whānau and their communities. This requires us to work with people, instead of doing things to them or for them. Only by working together, can we gain an understanding of how people want to be supported. Success depends on establishing relationships with our patients, whānau, iwi and communities, as well as with other providers and agencies whose policies support health and wellbeing.

People expect to be able to find their way around easily and for services to be oriented around their needs. Our challenge is to integrate services so well that it feels like one consolidated health system – Health Auckland.

Our district health board has built a firm foundation for supporting good health and for providing quality health services. We are proud of this role and aspire to the consistent delivery of world-class care. We will do more to upskill our workforce so staff can work in more people-centric and patient-centric ways.

Our strategic themes set the direction for activities over the next four to five years. They tell us what to do and they keep us focused on the things that matter most. The strategic mandatories and our organisational values tell us how to work, making explicit the approaches that underpin everything we do and which characterise the Auckland DHB way.

Strategic Themes

Our strategic themes set the direction for the way our services will be planned, developed and delivered in the future and ensure our vision of '**healthy communities, world-class healthcare, achieved together**' is realised. They highlight the need for us to organise our efforts in a different way to deliver more for our population.

Community, whānau and patient-centric model of care

Our job is to support people to live well and stay well, making sure that people are well-informed about health and able to determine the health outcomes they want. What matters to communities, patients and whānau should guide how the DHB thinks, acts and invests.

Emphasis/ investment on treatment and keeping people healthy

We deliver 'world-class healthcare' but also work to prevent ill health. Investing up front helps to reduce illness and early deaths while reducing the downstream cost of hospital care. We support people to stay healthy and independent as they age. Our resources are directed to the areas and communities of high need.

Service integration and/or consolidation

Health and disability services need to be conveniently located and easy to access. By collaborating around the needs of the patient, we can deliver the right services in the right place and by the best person. The DHB can create a seamless experience of care as people move between services.

Intelligence and insight

We need to accelerate progress towards a regional electronic health record that will be shared by, and will integrate, the patient and all the key people in a person's care. This is critical if we are to realise the potential of the 'big data' available in our system for population health gain. Feedback from our patients, communities and staff can be used more effectively in planning.

Consistent evidence informed decision making and practice

We aspire to have our practices and decisions based on the best available evidence. Our academic partnerships allow access to world-class training, research and evidence help us to deliver safe, effective, world-class care. Co-design work with patients, families and communities provides vital information about health.

Outward focus and flexible, service orientation

A focus on long-term population health outcomes is required to reduce inequalities in health status. We need to work with other agencies to achieve this. We will minimise bureaucracy and make the most of services. We have a statutory accountability for the health of Aucklanders and will speak out on important issues.

Emphasis on operational and financial sustainability

Auckland DHB takes patients from all over New Zealand and the Pacific. We will shift the focus of planning from the volume of work to the value of work, from outputs to outcomes. Our savings strategy ensures we keep searching for value and efficiency and look for opportunities to increase revenue. We are working to reduce clinical and financial risk through collaborative cost-effective services between the four regional DHBs.

Strategic outcomes in a national, regional and sub-regional context

National

Auckland DHB operates collectively as part of a national health system. The overall direction and outcomes for the health sector are set by the Minister's expectations. For 2016/17, these are:

- Refreshed New Zealand Health Strategy
- Living within our means
- Working across Government
- Shifting and integrating services
- National Health Targets
- Tackling obesity
- Health IT programme 2015–2020.

Auckland DHB is committed to actively working with other agencies to achieve the sector goals related to the Government's Better Public Services initiatives – particularly focusing on vulnerable children and families, and reducing unintended teenage pregnancies. We will continue to work with New Zealand Health Partnerships Limited to progress the 2016/17 initiatives.

The Paediatric subgroup of the Spinal Cord Impairment (SCI) Governance Group (with national representation on the subgroup) is engaged in the development of pathways and protocols for SCI, as well as integrated rehabilitation work in collaboration with Waitemata DHB. The subgroup monitors and reports against the SCI Action Plan.

The New Zealand Health Strategy was published recently. The refreshed strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Auckland DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'.

The overarching vision and the five strategic themes are illustrated in the diagram below. Details of the actions we are taking to contribute to the New Zealand Health Strategy are set out in Module 2A.

Regional

The Northern Region Health Plan (NRHP) has been developed by the four Northern Region DHBs and primary care Alliance Partners; it provides an overall framework to demonstrate how the Government's objectives and the region's priorities for regional work will be met during 2016/17 and beyond.

The Northern Regional Alliance (NRA) oversees the NRHP. The NRA continues to ensure regional alignment of plans, and appropriate stakeholder representation and involvement, by having clinical network and workgroup memberships drawn as appropriate from each of our region's DHBs and with representation from across the primary-secondary continuum of care. The overall direction and strategic intent of the 2016/17 NRHP is to achieve gains across the Triple Aim Framework and reflect the themes of the draft New Zealand Health Strategy.

Sub-regional

Auckland and Waitemata DHBs have a bilateral agreement that joins governance and some activities where there is mutual benefit to the planning and delivery of providing enhanced, sustainable health services to over one million Aucklanders. The two DHBs share a Board Chair and have advisory committees that meet jointly. The merger of a number of teams, including planning, funding and outcomes, has increased consistency of relationships across the two DHBs.

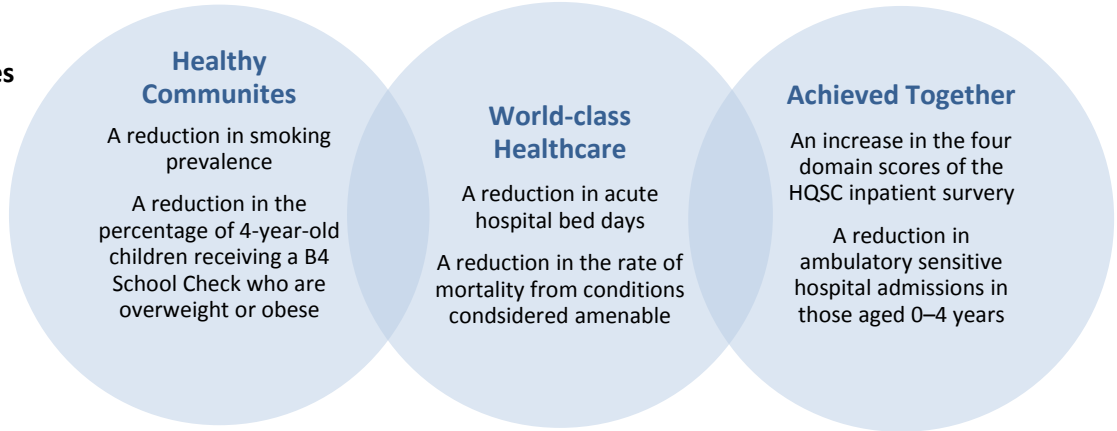
Intervention logic and outcomes framework

The intervention logic and outcomes framework for Auckland DHB summarises the key national, regional and local priorities that inform this 2016/17 Annual Plan, and demonstrates our commitment to an outcomes-based approach to measure performance, including the key measures we monitor to ensure we achieve our objectives. Our outcomes framework enables the DHB to ensure it is achieving its vision and delivering the best possible outcomes across the whole system for our population.

Outcome measures and supporting impact indicators have been identified that will support achievement of these overall goals. The outcome measures are long-term indicators (up to 10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target. We will report on progress against these measures in the DHB's Annual Report.

Our outcome and impact measures are presented in the intervention logic diagram on the following page. The diagram demonstrates how the services that we choose to fund or provide (outputs) will impact the health of our population and result in the achievement of desired longer-term outcomes and the expectations and priorities of Government. The Statement of Performance Expectations in Module 3 details a set of output indicators that contribute to our overall outcomes framework, and we will report against these in the DHB's Annual Report.

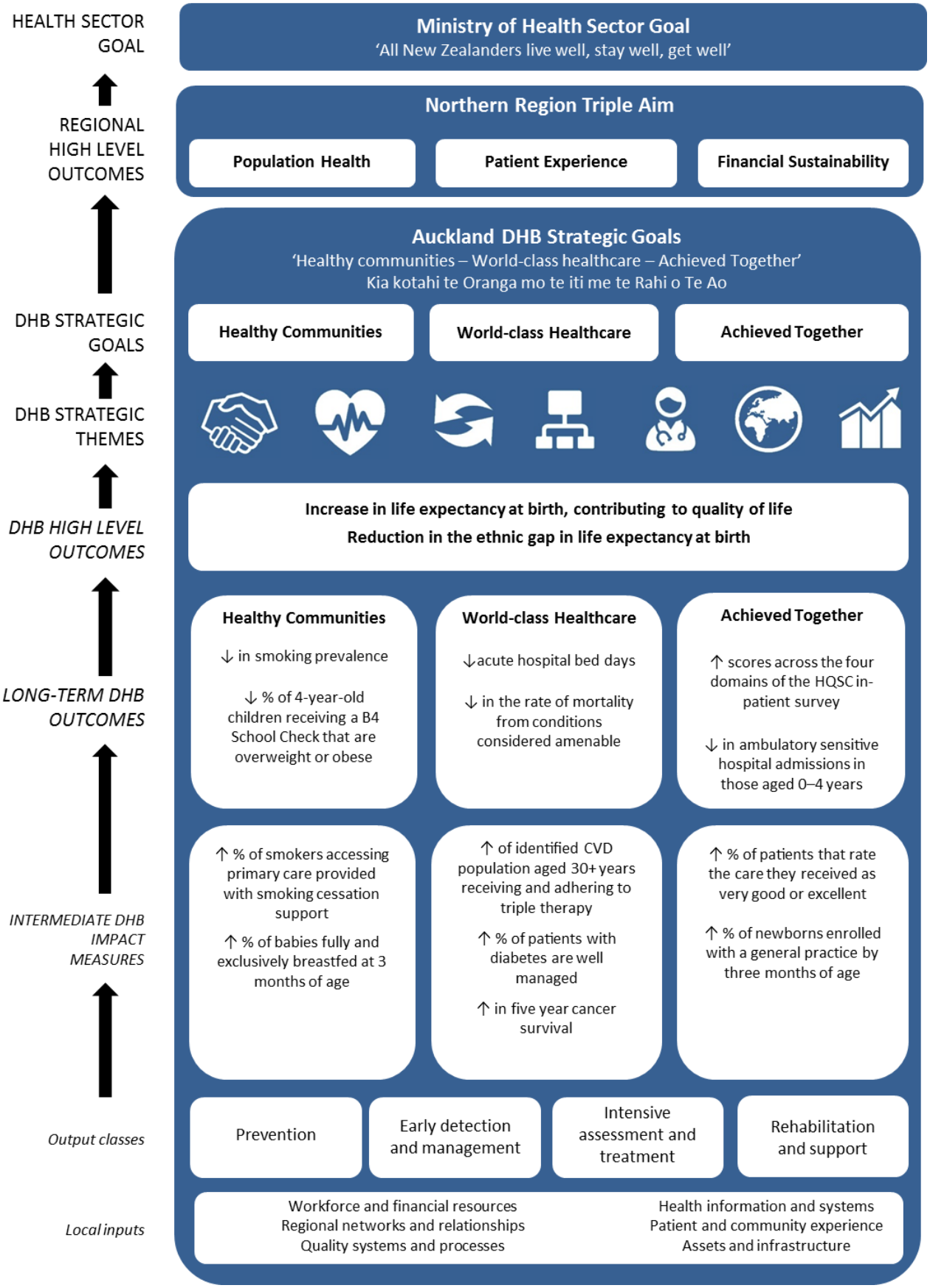
Outcomes



Impact measures

- An increase in the percentage of smokers accessing primary care provided with smoking cessation support
- An increase in the percentage of babies fully and exclusively breastfed at 3 months
- An increase of identified CVD patients aged 30+ years receiving triple therapy
- An increase in the percentage of patients with diabetes who are well managed
- An increase in five year survival from cancer
- An increase in patients that rate the care they received as very good or excellent
- An increase in the percentage of newborns enrolled with a general practice by three-months of age

Intervention logic and outcomes framework



Note: two new system level outcome measures will be introduced in 2017/18 – number of babies who live in a smokefree household at 6 weeks post-natal and youth access to and utilisation of youth appropriate health services.

Overall outcomes

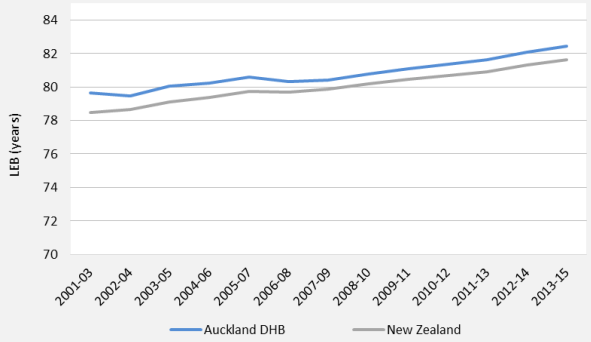
The overall outcomes that we want to achieve are to increase life expectancy and quality of life (measured by life expectancy at birth) and to reduce ethnic inequalities (measured by the ethnic gap in life expectancy). As general measures for the quality of life are less well developed, we have not identified a single overall measure of quality of life. Many of our outcome and impact indicators can act as proxy indicators for overall health gain, which is one domain that is likely to contribute to quality of life.

Overall outcome – Increase life expectancy and quality of life

Life expectancy at birth (LEB) is recognised as a general measure of population health status. In Auckland, life expectancy has increased by 2.4 years over the last decade, a similar increase to that seen in New Zealand. Overall, we continue to have one of the highest life expectancies in the country at 82.4 years (2013–15).

Over the longer term, we aim to continue to increase life expectancy, maintaining a 2.4-year increase in life expectancy over the next decade.

Outcome Measure – An increase in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Overall outcome – Reduce inequalities for all populations

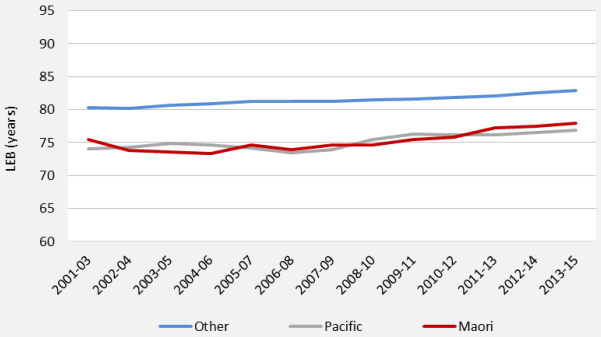
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a life expectancy lower than other ethnicities, with a gap of 4.9 years for Māori and 6.0 years for Pacific (2013–15). Over the past decade, the gap has increased slightly for our Pacific population and declined by over 2 years in our Māori population.

Mortality at a younger age from diseases of the circulatory system and cancers account for around 3.3 years of the life expectancy gap in Māori, and around 3.8 years of the gap in Pacific. In our Māori population, a further 1.2 years of the gap can be attributed to injury and other external causes of mortality. In our Pacific population, a further 1.5 years of the gap can be attributed to endocrine, nutritional and metabolic diseases, for example diabetes.

Although life expectancy is increasing across all ethnic groups, the rate of increase is not as large in our Pacific population, having only increased by 2.0 years over the past decade. The increase in life expectancy is most pronounced in our Māori population, having increased by around 4.4 years over the past decade.

We expect to see a reduction in the gap in life expectancy over the next decade, declining at at least the same rate as observed in the last ten years.

Outcome Measure – A reduction in the ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. 'Other ethnicity' includes non-Māori/non-Pacific ethnicities

Healthy Communities

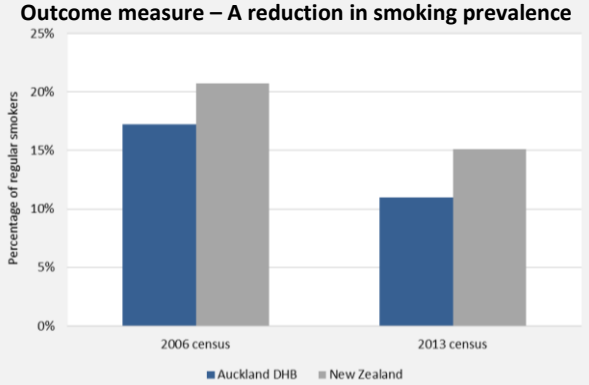
To improve health outcomes and ensure health equity, we want to see Aucklanders take greater responsibility for their own health, at home and in their communities where real health belongs. Everyday lifestyle choices make a difference to individual health. Our focus is on smoking and childhood obesity. Our aim is to create health-promoting physical and social environments, which support people to take more responsibility for their own health and make healthier lifestyle choices.

Outcome – A smokefree Auckland by 2025

Smoking is the leading modifiable risk factor for many diseases and we estimate is responsible for 300 deaths and a large number of hospitalisations in Auckland every year. Targeting smoking provides us with an opportunity to reduce inequalities and drive improvements in the overall health of our population.

The prevalence of smoking in Auckland DHB was 11.2% according to census 2013. This is the lowest prevalence of any DHB in the country. Smoking is associated with many cancer-related deaths and hospitalisations and there are significant ethnic differences in our district, with Māori and Pacific people more likely to smoke (26% and 22%, respectively).

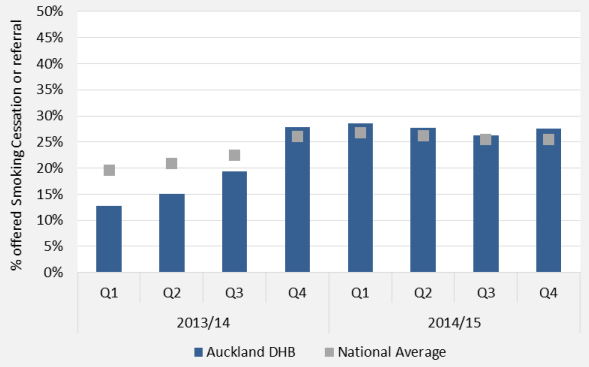
Outcome measure – A reduction in smoking prevalence



Brief advice to stop smoking and, most importantly, an offer of behavioural cessation support by a health professional can significantly increase the number of people who attempt to, and succeed in, stopping smoking. Many people who attempt to quit will experience a lapse during their quit attempt. Behavioural support, such as a referral to 'quit smoking' services and pharmacological smoking cessation aids, will help prevent a lapse becoming a return to regular smoking.

We have seen an increase in the proportion of smokers accessing primary care who are provided with smoking cessation support. Our aim is to continue this trend and ensure we are supporting smokers in their quit attempt.

Impact measure – An increase in the percentage of smokers accessing primary care provided with smoking cessation support



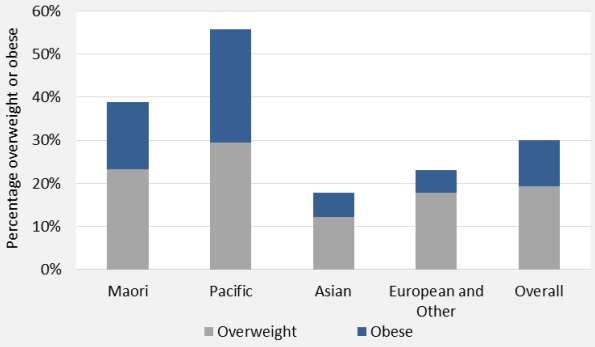
Outcome – Reduce obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Childhood obesity is associated with a wide range of health complications and an increased risk of premature onset of illnesses, including diabetes and heart disease. In the context of lifelong health, children who become overweight and obese are at higher risk of obesity throughout their lives. Children that are overweight or obese face higher risks of negative economic and social outcomes in both childhood and adulthood. Therefore, intervening early to reduce the prevalence of overweight and obesity will have long-term positive effects for population health.

Although the prevalence of obesity in children is lower in Auckland compared with New Zealand, it is increasing. The prevalence is higher in Māori (15.6%) and Pacific (26.3%) children compared with Asian (5.6%) and other ethnicities (5.2%). In 2015, nearly one in three of our four-year-old children was overweight or obese.

We aim to reverse the trend in increasing rates of obesity over the intermediate term.

Outcome Measure – A reduction in the percentage of four year old children receiving a Before School Check that are overweight (85th – 97th percentile) or obese (≥97th percentile)

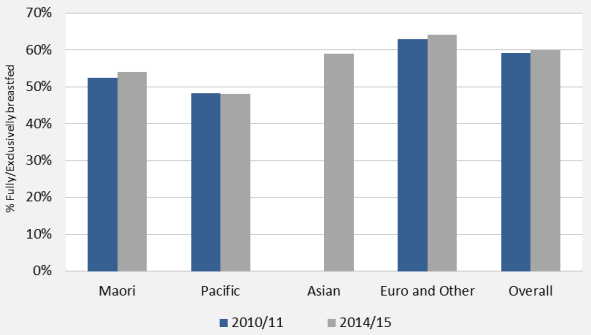


Outcome – Reduce obesity

Breastfeeding helps to lay the foundations for a healthy life, providing the nutrition required for healthy development as well as other immediate and long-term health benefits. Breastfeeding helps protect against common childhood infections and reduces the risk of obesity and non-communicable diseases (such as diabetes and asthma) later in life. Breastfeeding also provides health benefits for mothers and assists bonding between mothers and babies.

Together with other targeted nutrition and lifestyle interventions and healthy public policy, increasing breastfeeding rates can be an important component of strategies to reduce the risk of overweight and obese children. Small but steady gains have been made over recent years in the number of mothers who breastfeed.

Impact Measure – An increase in the percentage of babies fully and exclusively breastfed at 3 months of age



World-class Healthcare

We aim to ensure our population has rapid access to healthcare that is timely, reliable, equitable, high quality and safe. Significant progress has been made over recent years, which is reflected in the declining rates of mortality from CVD and cancer, as well as other conditions that are considered treatable through the provision of timely and high quality healthcare. However, more can be done to increase the number of years of healthy life lived and reduce disability for our patients, particularly for our Māori and Pacific population, and the societal and economic burden that long-term conditions and avoidable deaths carry.

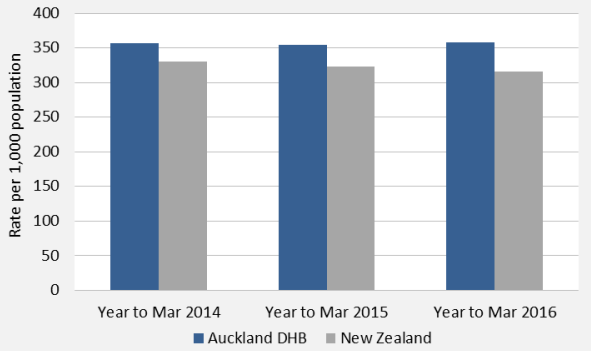
Outcome – A reduction in acute hospital bed days

Acute admissions account for approximately one third of all hospital admissions in New Zealand. The consequences of increasing numbers of acute admissions include: the fiscal challenges, a reduced ability to undertake non-urgent work, increased pressure on staff and difficulties with planning staffing levels.

Our standardised rate of acute bed days has remained stable since 2014 and is higher than the National rate at 358 per 1,000 population compared with 315 per 1,000 population nationally.

A focus on reducing acute hospital admissions will, in the short term, consider the effectiveness of interventions to manage chronic disease and, in the longer term, the importance of preventing the development of these diseases.

Outcome Measure – A reduction in acute hospital bed days

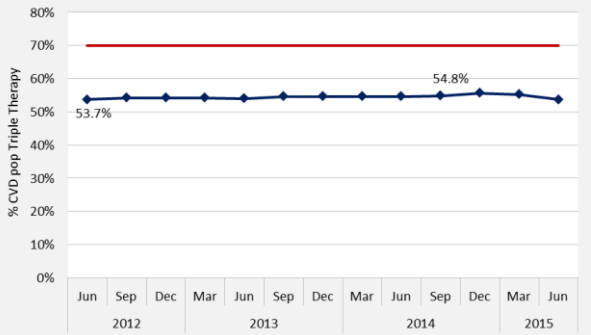


*Age standardised rate

Current New Zealand guidelines recommend that people who experience a heart attack or stroke (where appropriate) should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin). The Northern Region Cardiac Network has agreed that our aspirational target should be 70%.

We intend to make sure that our patients who have had a CVD event are receiving the best possible care. Currently, 54% of our population who have had a CVD event are prescribed ongoing triple therapy medication.

Impact Measure – An increase of identified CVD population aged 30+ years receiving triple therapy

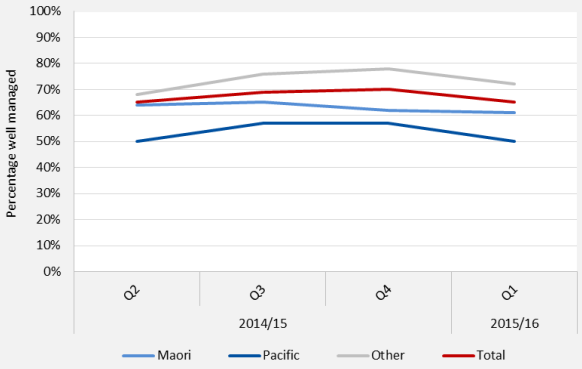


Outcome – A reduction in acute hospital bed days

Diabetes is a chronic illness that requires continuous medical care, patient self-management and education to reduce the risk of acute and long-term complications. How well a patient is managing their diabetes can be monitored through regular assessment of their HbA1c (an indicator of glycaemic control).

In Q1 2015/16, 65% of our patients with diabetes were managing their condition well. However, significant inequalities exist within our Māori and Pacific populations. Only 61% of Māori and half of Pacific patients with diabetes are well managed. There is significant room for improvement for our Māori and Pacific populations, which will likely lead to a reduction in diabetic complications in these populations.

Impact Measure – An increase in the percentage of patients with diabetes that are well managed at their annual review

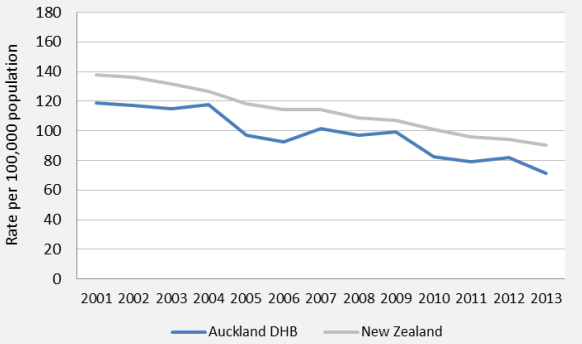


Outcome – Reduced mortality from conditions considered amenable

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

The rate of amenable mortality has steadily decreased over the past decade and is among the lowest in New Zealand at 71.2 per 100,000 population. In 2013, we estimate that 372 deaths (45.6% of all deaths in those aged under 75 years) in Auckland DHB were amenable. We aim to continue the reduction in amenable mortality at the same rate observed over the past decade.

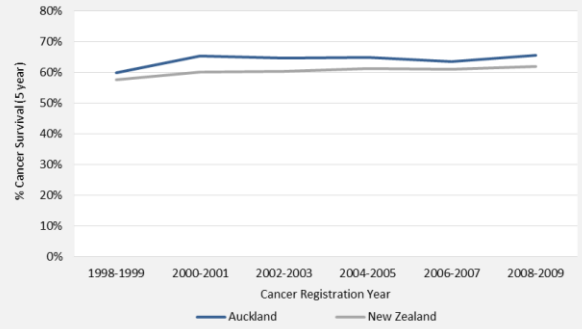
Outcome Measure – A reduction in the rate of mortality from conditions considered amenable



Cancer survival is a key indicator of the impact of cancer on society. It is also a valuable way of measuring the success of our cancer control activities including treatment and early detection.

We have seen a steady rise in the five-year survival ratio for people diagnosed with cancer in our district. For all individuals diagnosed with new cancer in 2008–2009, the five-year survival ratio was 65.6%, meaning that among those diagnosed with cancer, the cancer reduced the likelihood of surviving five years after diagnosis by 35%.

Impact Measure - An increase in five-year cancer survival ratio



Achieved Together

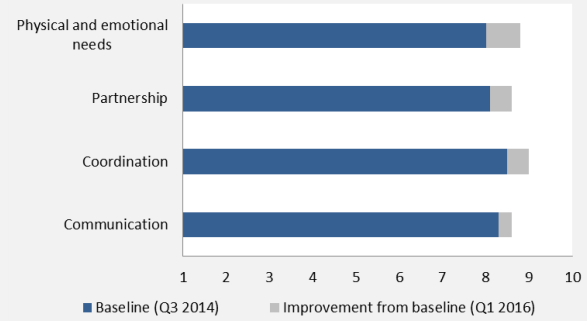
People are at the centre of our work. Our approach is to empower people to be active in their communities, and working as active partners across the whole system: staff, patients, whānau, iwi, communities, trainers and others. Patients expect to manage their own health, to determine the care they want and how it is delivered. Models of care need to be designed around the patient and coordinated so that patients get what they need, in the right place at the right time. Services and care plans need to be tailored to the individual and oriented to the things that matter. Our focus in this area is on ensuring our patients have an improved experience of health care services and that our children are engaged early with high quality primary and community services, to ensure they get the best start in life.

Outcome – Improved experience of health care services

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. Our focus is on individualised care, tailoring services to meet patient and whānau needs, and engaging them as partners in their care.

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. Our average scores out of ten have steadily improved since the survey was implemented and are similar to New Zealand as a whole. We would like to accelerate improvement in this rating, aiming to consistently reach at least 9.0 in each domain in the intermediate term.

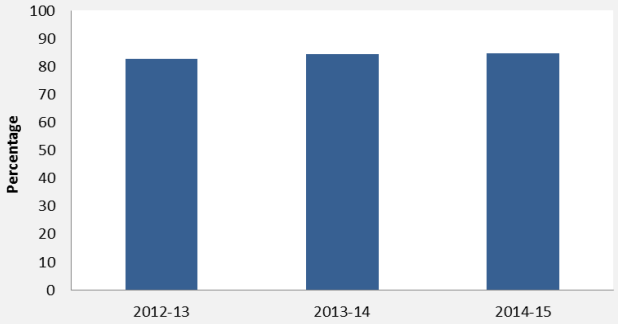
Outcome Measure – An increase in the average score across the four domains of the Health Quality and Safety Commission (HQSC) inpatient survey



An enhanced patient experience leads to better emotional health, symptom resolution, less reported pain and more effective self-management. Patients who feel that all aspects of their health care experience have been well managed are more likely to rate their care as very good or excellent.

The percentage of our patents rating the care they received as 'very good' or 'excellent' has increased slightly from 82.6% in 2013/14 to 84.7% in 2014/15.

Impact Measure – An increase in the percentage of patients that rate the care they receive as very good or excellent



Outcome – Children receive the healthiest start to life

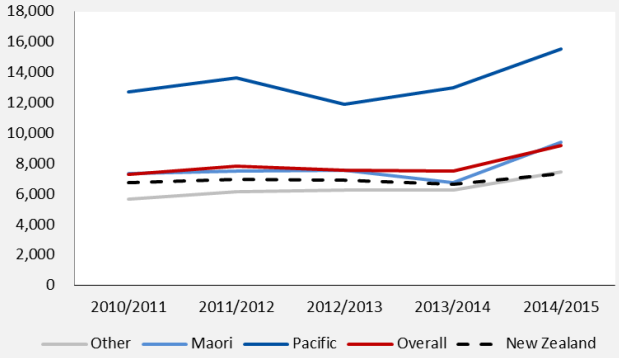
Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Well integrated, high quality primary and community services can maintain good health, prevent health problems and improve health outcomes.

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital that are considered reducible through preventative or therapeutic interventions delivered in primary care. ASH rates highlight the burden of disease in childhood, with a strong emphasis on health equity.

In the 12 months to June 2015, there were 9,182 admissions per 100,000 in our 0–4 year old population (2,682 events) that were considered to be ambulatory sensitive.

Our aim is to reduce this to below the national average and reduce the gap in equity for our Māori and Pacific children.

Outcome Measure – a reduction in ambulatory sensitive hospitalisations (ASH) rates for 0–4 year olds



Outcome – Children receive the healthiest start to life

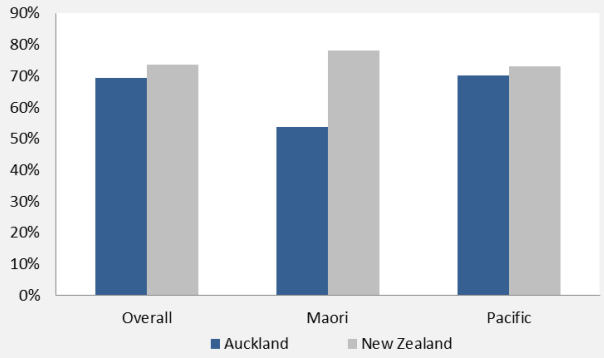
Ensuring babies have been enrolled with a general practice soon after birth means they can receive essential health care, including immunisations and other health checks on time.

Research shows that an established relationship with the primary health care provider is a critical factor in the timely delivery of health care for young children.

The percentage of newborns enrolled with a general practice by three months of age as at Q4 14/15 was 69%. This is lower than the national rate and among the lowest in the country. Enrolment has increased slightly from 66% in the previous year. Significant inequalities exist, with only 54% of Māori children enrolled with a general practice by three months of age.

Impact Measure – An increase in the percentage of newborns enrolled with a general pract

ice by three months of age



MODULE 2A: Implementation of the New Zealand Health Strategy

The refreshed New Zealand Health Strategy provides DHBs with a clear strategic direction and road map for delivery of more integrated health services into the future. Auckland DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'. The current themes of the Strategy provide a focus to drive change:

- People powered
- Care closer to home
- Value and high performance
- One team
- Smart system.

The Strategy's Roadmap of Actions sets out 20 work areas to put the Strategy in place. Although the Strategy has a ten-year horizon, we will begin implementation of the strategy in 2016/17. We are already planning to deliver activities that will contribute to the draft Roadmap Actions, under existing priority areas, and these are identified in the below table.

Health Strategy Action	Priority Area (Module 2B, unless stated)
Theme: People Powered	
1. Inform people about public and personal health services so they can be 'health smart' and have greater control over their health and wellbeing	Module 5 – Building Capability; Promoting healthy lifestyles and wellbeing; High quality, safe, dependable services; Reducing health inequalities
2. Make the health system more responsive to people	Patient Experience and Community Participation; Reducing health inequalities; Supporting Vulnerable Children; Health of Older People; Mental Health; PM's Youth Mental Health Project
3. Engage the consumer voice by reporting progress against measures important to the public, building local responses and increasing participation of priority groups	Patient Experience and Community Participation; Reducing health inequalities
4. Promote people-led service design, including for high-need priority populations	Patient Experience and Community Participation; Reducing health inequalities; Whānau Ora
5. In selected high-need communities, build on, align, clarify and simplify multiple programmes of social investment.	Reducing health inequalities; Whānau Ora; Service Configuration; Promoting healthy lifestyles and wellbeing
Theme: Closer to Home	
6. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way	Service Configuration; Reducing health inequalities; Living within Our Means
7. Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training	Module 5 – Workforce
8. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity	Tobacco; Obesity; Reducing health inequalities; Cardiovascular Disease; Living Well with Diabetes; Cancer; Mental Health
9. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, families and whānau, particularly those at risk	PM's Youth Mental Health Project; Supporting Vulnerable Children; Whānau Ora; Rheumatic Fever; Increased Immunisation
10. Involve health and other social services in developing shared care for older people with high and complex needs in residential care facilities or those needing support at home	Health of Older People
11. Support clinicians and people in developing advance care	Module 3 – Statement of Performance

Health Strategy Action	Priority Area (Module 2B, unless stated)
plans and advance directives	Expectations
12. Review adult palliative care services to ensure all those who would benefit from palliative care at the end of their life are able to access high quality care and have a seamless experience.	Service Configuration
Theme: Value and High Performance	
13. Enable people to be partners in the search for value by developing measures of service user experience and improving public reporting	Patient Experience and Community Participation
14. Implement framework focused on health outcomes to better reflect links between people, their needs, and outcomes of services	System Level Outcomes; Module 1 – Outcomes Framework
15. Work with the system to develop a performance management approach with reporting that makes the whole system publicly transparent	Module 1 – Outcomes Framework; Module 3 – Performance Expectations
16. Maintain the direction set by the Strategy through monitoring and evaluation, and advice from a Strategy Leadership Group	Living within Our Means; Module 5 – Building Capability
17. Align funding across the system to get the best value from health investment	MoH action
18. Continue to develop the application of the social investment approach to health investment with DHBs. Consider using this approach to improve overall outcomes for high need priority populations, while developing and spreading better practices	MoH action MoH action
19. Continuously improve system quality and safety.	Improving Quality
Theme: One Team	
20. Improve governance and decision-making processes across the system in order to improve overall outcomes by focusing on capability, innovation and best practice	Improving Quality
21. Clarify roles and responsibilities and accountabilities across the system as part of the process of putting the Strategy into action	MoH action
22. Create a 'one team' approach to health in New Zealand through an annual forum for the whole system to share best practice and help build a culture of trust and partnership	Module 5 – Workforce
23. Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector	Annual Planning days; Health of Older People; Whānau Ora; Module 5 – Workforce
24. Put in place workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.	Whānau Ora; Module 5 – Workforce
Theme: Smart System	
25. Increase New Zealand's national data quality and analytical capability to make the whole health system more transparent and provide useful information for designing and delivering effective services	Module 5 – Building Capability
26. Establish a national electronic health record that is accessed via certified systems, including patient portals, health provider portals, and mobile applications	Module 5 – Building Capability
27. Develop capability for effective identifying, developing, prioritising, regulating, and introducing knowledge and technologies.	Module 5 – Building Capability

MODULE 2B: Our Goals and Priorities

To focus our work for the next year, we have developed specific goals and associated actions that will move us towards them. We will report performance against these deliverables and measures to the Ministry of Health (where required), our Board and Board committees as appropriate.

Healthy Communities

Aucklanders expect to have the best start in life, with the support they need to be healthy, active and independent. People need help at various stages of their life, and this increases towards the end of life. Our approach is to empower our population to determine the health care and support they want for themselves, their whānau and communities. People need help to stop smoking, eat healthily and exercise more; healthy homes are also important in preventing illness and early death. Dedicated services are needed for Māori, where we have responsibilities under Te Tiriti o Waitangi, and other high need groups.

Our goal is to:	Achieve the best, most equitable health outcomes for the populations we serve

Promoting healthy lifestyles and wellbeing

Common lifestyle choices, such as smoking, lack of physical activity and poor nutrition, are major contributing factors of disease. Addressing these factors will help to mitigate our increasing incidence of preventable chronic disease. More support is needed to help vulnerable population groups stay well.

Tobacco

Smoking is the largest single cause of preventable ill health and premature death. The smoking rate has declined substantially in our adult population from 16.5% in 2006 to 11% in 2013. Our district has the lowest smoking rate in the country, and this decline will positively affect health as we work towards achieving the Government's Smokefree 2025 goal. Despite the decline in smoking rates, significant ethnic disparities still exist in our district. Our 'Ask, Brief advice, and Support to Quit' programme provided quit advice to around 86% of smokers who have accessed primary care in the last 15 months.

Tobacco

Health outcome: A smokefree Auckland by 2025 (<5%)

What are we aiming for in 2016/17? (Our measures)

Key measures

- Achievement of Smokefree 2025: 5% or less of the population (of all ethnic groups) identify as smokers by 2025
- Progress against the health target: 90% of PHO-enrolled patients who smoke are offered help to quit smoking by a health practitioner in the last 15 months
- Progress against the health target: 90% of pregnant women who identify as smokers at registration with a DHB-employed midwife or Lead Maternity Carer are offered quit advice and support.

Other measures

- 95% of Māori women are smokefree at two weeks post-natal (an MoH Māori Health target)
- 80% of Mental Health and Addiction service users have their smoking status recorded and receive advice and an offer of support to quit.

How will we achieve this?

Smokefree 2025

Meet the Government goal of 'Smokefree Aotearoa 2025' through implementation of the Smokefree 2025 roadmap (Ministry's foundation document to guide activity) of:

- Protecting children from exposure to tobacco marketing and promotion – ongoing

Tobacco

- Providing the best possible support for quitting – ongoing
- ARPHS to lead the development of a Smokefree Health Promotion Strategy to reduce smoking uptake, prevalence and inequities – December 2016.

Supporting achievement of the Better Help for Smokers to Quit primary care health target

- Contract with each PHO to lead and coordinate support to General Practices to meet the health target, including setting key performance indicators, regular feedback on performance, training and clinical leadership – ongoing
- Implement initiatives to increase the number of smokers that make supported quit attempts, particularly for Māori, Pacific and pregnant women – June 2017.

Supporting achievement of the hospitals indicator

- Maintain the 'Ask, Brief Advice and Support to Quit' approach by providing training, resources and support to the Smokefree Lead in each inpatient hospital service – ongoing
- Set a hospital target for the percentage of smokers that make a supported quit attempt (prescribed NRT and/or accept a referral to a Stop Smoking Service) – October 2016.

Supporting achievement of the maternity health target

- Plan for implementing the new System Level Measure of 'number of PHO-enrolled babies who live in a smokefree household at the 6-week vaccination' by June 2017.

Support Mental Health and Addiction Services to be smokefree

- Support the DHB and regional Mental Health and Addictions NGO Smokefree project – ongoing
- Make the recording of smoking status in the client's medical record mandatory by December 2016
- Northern Regional Alliance to coordinate and complete a mass quit challenge (with incentives) for Mental Health and Addiction Service users and staff – by June 2017.

DHB leadership and innovation

- Build relationships and referral pathways with the new Stop Smoking services that the MoH contracts with in the Auckland and Waitemata DHB areas – December 2016
- Update resources that list the Stop Smoking Support services that are available and promote these services across the districts – December 2016
- Implement a pilot programme of youth initiated smoking prevention strategies with lessons informed by the work undertaken with schools in 2015/16 – December 2016
- Pilot an initiative to support staff to stop smoking in ARPHS – June 2017.

Obesity

Low levels of physical activity and poor nutrition affect the health of our population. Ensuring our children have access to and receive the right messages about nutrition and physical exercise will help them to become healthy adults. Nearly one in three of our four-year-old children are obese or overweight. Although our obesity rates in children are lower than the national rates, they are increasing.

Obesity

Health outcome: Reduced childhood obesity

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Health Target: 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.

Other measures

- 50% of pregnant women of all ethnicities with gestational diabetes are referred to Green Prescription by June 2017
- 60% of babies of all ethnicities are fully or exclusively breast-fed at three months of age

Obesity

- At least 73% of four year olds are at a healthy weight at the B4SC.

How will we achieve this?

- Implement the regional obesity framework and, as part of Healthy Auckland Together (HAT), work collaboratively with key stakeholders across health and other sectors including Auckland Regional Public Health Service (ARPHS), Council and Pacific networks – ongoing.

Population and Pre-conception: ***Enabling healthy environments, knowledge and skills to support healthy choices***

- Agree a national DHB food and beverage environments policy by August 2016, and work towards compliance with the policy by June 2017
- Map the food environment of ECEs, schools, DHBs and other community settings around schools in collaboration with HAT partners by June 2017
- Collaborate with HAT, Kai Auckland and the Auckland Social Sector Leadership Group to engage intersectorally with social services and non-health organisations to support healthy food environments from July 2016
- Extend the reach of the Aiga Challenge programme by June 2017
- Survey Pacific people who have maintained weight loss on enablers to weight loss maintenance by December 2016, and utilise findings to develop programme strategies by June 2017
- Develop an adult overweight health pathway, including information resources and a bariatric pathway by June 2017.

Maternal and First Year of Life: ***Supportive environments and best care for healthy pregnancies and the first year of life***

- Strengthen connections with maternity services and with kohanga reo and Pacific ECE centres to increase access to the Healthy Babies Healthy Futures (HBHF) programme for Māori, Pacific and Asian women and their families by December 2016
- Identify the number of pregnant women engaged with HBHF with healthy weight gain in pregnancy
- Work with primary care, Green Prescription providers, LMCs, DHB maternity services and HBHF to increase Green Prescription referrals and provide tailored advice for pregnant women by June 2017
- Provide culturally appropriate breastfeeding support to women and their families via trained peer support, improved health professional health literacy (primary care, LMCs and community workers) by June 2017
- Increase access to evidence-based nutrition and activity information for pregnant women through the Pregnancy and Parenting app and website by June 2017
- Work with DHB birthing facilities to establish a baseline population measure for monitoring BMI and maternal obesity in DHB by September 2016.

Childhood: ***Supportive environments and best care for a healthy childhood***

- Resource Plunket as the contracted B4 School Check provider to maintain timely referral processes in line with the health target, and to provide additional advice on nutrition, activity and parenting to parents and caregivers of obese 4-year-old children from June 2016
- In line with the Ministry's service specification, engage providers of services for obese pre-schoolers through an RFP process by June 2017
- Develop and pilot a brief intervention and goal setting resource with B4SC to ensure consistent health promotion messages across community, primary and secondary care by December 2016
- Develop a family-based nutrition, physical activity and parenting programme, and a quantitative indicator to monitor the programme's effectiveness - by June 2017
- Through the Regional Child Health Network, ensure regionally consistent pathways of care and a streamlined referral pathway to community programmes for overweight and obese children by December 2016
- The B4SC Governance Group, including Māori and Pacific representatives, will support local implementation of the regional referral pathway and monitor referral rates of 4-year-old children to ensure equity for Māori, Pacific, and children living in high deprivation areas by December 2016

Obesity

- With primary care, community programmes and paediatric outpatients, investigate shared clinical opportunities to provide advice and support for children and families by December 2016.

Increased Immunisation

Immunisation is an effective means of protecting children from infectious diseases throughout life. Our immunisation coverage is high, at 94% for 8-month-olds and 95% for 2-year-olds. We aim to meet and sustain performance against the national target of 95% in the coming year.

Increased Immunisation

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure

- 95% of 8-month-old children of all ethnicities are fully immunised by June 2017.

Other measures

- 95% of 2-year-old and 5-year-old children of all ethnicities are fully immunised by June 2017
- At least 70% of all 12-year-old girls (2003 birth cohort) of all ethnicities have completed all doses of their HPV vaccine by 30 June 2017
- 98% of newborn children are enrolled with a GP by 3 months of age.

How will we achieve this?

- Monitor all Immunisation coverage rates weekly with a focus on achieving equity for Māori, Pacific and high-deprivation populations – ongoing
- With Ngati Whatua, WCTO, PHOs, oral health and DHB partners, maintain a Māori Immunisation Reference Group to share information and agree actions to support Māori whānau and babies who have overdue immunisations from July 2016
- Create an action plan based on results of the audit 'From Hospital to General Practice', to drive further alignment of processes across tertiary, secondary and primary care regarding follow-up of children not fully immunised and those eligible for special immunisations by December 2016
- Maintain the effectiveness of the Joint Auckland DHB and Waitemata DHB Immunisation Steering and Operations Groups and Auckland Metro School Based Immunisation Working Group
- Work with PHOs and NIR/OIS on the Shared Approached Plan to develop a pathway for early enrolment and B-code enrolment of all newborns with general practices by July 2017
- Provide at least four joint DHB/PHO education workshops for primary and secondary care providers, and school-based nurses, addressing vaccine hesitancy and best practice by June 2017
- Facilitate education workshops for secondary care providers to enable opportunistic immunisation in DHB facilities including renal, ED and maternity services by June 2017
- Provide two funded Midwives Immunisation Education sessions to provide an annual update on Antenatal Immunisation by June 2017
- With primary care, B4SC providers and the education sector, develop processes for promotion and information sharing to increase immunisation coverage for all 4-year-olds by 30 December 2016
- Conduct a data-cleansing project with NIR/OIS, PHO and general practices to verify all 4 year old immunisations given are recorded on the NIR by October 2016
- Review the current school-based immunisation programme to identify areas to improve coverage by December 2016, and work with PHO Immunisation Coordinators to ensure young people who decline the school-based immunisation programme are recalled by their GP by February 2017
- Review school-based immunisation processes in readiness for potential changes to adolescent immunisation schedule by December 2016
- Work with ARPHS to develop a plan to promote Immunisation Week 2017 by February 2017.

Rheumatic Fever

Reducing the burden of rheumatic fever is a national priority. Our rapid response services and school-based programme make it easier for young people in high incidence areas to get their sore throats checked and treated if necessary. In 2015, 7,287 children were throat swabbed as part of our school-based rheumatic fever programme. Our rate of rheumatic fever was 3.2 cases per 100,000 in 2014/15. This is a decrease on the 2013/14 rate of 3.7 cases per 100,000.

Rheumatic Fever

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure

- Reduce rheumatic fever rate to 1.1 per 100,000 people by June 2017.

How will we achieve this?

Governance

- Achieve effective programme oversight through the joint Waitemata and Auckland DHBs Rheumatic Fever Steering Group by June 2017
- Review rheumatic fever service responses and delivery structures, including AWHI with regional partners and obtain Board approvals as required to maintain essential service elements by March 2017
- Develop a draft Rheumatic fever budget for activities from July 2017, investment plan prepared by January 2017.

Reducing the incidence of first episode rheumatic fever

- Engage PHOs to provide increased access to clinical leadership for their specific rapid response clinics – ongoing
- Promote rapid response clinics through localised community consultation events – ongoing
- Develop a Rheumatic Fever promotional campaign that utilises existing resources, to specifically engage Māori and Pasifika communities across Auckland and Waitemata DHBs, by June 2017
- Support PHOs to lead targeted activity to increase health literacy and access to sore throat clinics by June 2017
- Hold the school based 'HYPE' event 2016, a youth health priority event to promote rheumatic fever prevention and support youth rheumatic fever advocates, by September 2016
- Collaborate with Plunket/Tamariki Ora Well Child Providers to introduce rheumatic fever health messages within the B4School Checks by December 2016
- Monitor and increase the effectiveness of the Rapid Response Clinics in general practice and in pharmacy through the Rheumatic Fever Programme Clinical & Operations Group – ongoing
- Complete analysis and report on the cross-sectional survey of West Auckland caregivers and children at high risk of rheumatic fever by December 2016
- Ensure all eligible referrals for housing-related concerns are sent to the AWHI Hub and that systems and relationships support referrals to help keep families informed – ongoing
- Continue to work with the Ministry regarding AWHI and housing related funding and document this in a plan by Dec 2016
- Subject to further evaluation and consideration of the model of care by the Board (decision expected January 2017), maintain school-based rheumatic fever programmes in 16 primary schools
- Report quarterly to the Ministry on lessons learned and actions following the root cause analysis of cases of first episode rheumatic fever hospitalisations and implement relevant learnings – ongoing
- Implement the endorsed DHB Rheumatic Fever Prevention Plan.

Effective follow-up

- Ensure that all cases of acute and recurrent acute rheumatic fever are notified with complete case information to the Medical Officer of Health within seven days of hospital admission – ongoing
- Ensure patients with a history of rheumatic fever receive monthly antibiotics not more than 5 days after their due date – ongoing

Rheumatic Fever

- Audit rheumatic fever secondary prophylaxis coverage for children aged 0–15 years, youth aged 15–24 years, and adults aged 25+ years and report by June 2017
- Identify and follow-up known risk factors and system failure points in recurrent cases – ongoing
- Follow-up on any issues identified by the 2015/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic heart disease – ongoing.

Supporting Vulnerable Children

A key focus of the Government is vulnerable families. To protect vulnerable children in our district, we will support the prevention and early identification of child maltreatment. We will support cross-agency work that tackles the complex and long-term issues that some families face, particularly in priority populations, and we will meet the requirements of the Vulnerable Children Act.

Supporting Vulnerable Children

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure

- Reduce injuries in 0–14 year olds resulting from assault, neglect or maltreatment (baseline 10.26/100,000 2009–2013).

Other measures

- Reduce the number of unplanned uplifts of babies from maternity wards to less than 10
- Achieve an increased disclosure rate (from approximately 1% to at least 2%) in one Women's health ward that focuses on increasing the quality of the routine enquiry into intimate partner violence.

How will we achieve this?

Reduce mortality, morbidity and hospitalisations resulting from assault, neglect or maltreatment

- Maintain the strong intersectoral and leadership focus on child protection through Puawaitahi and extend the service's focus on building capability across the district and region – ongoing
- Maintain the Shaken Baby Prevention Programme – ongoing
- Monitor the effectiveness of Child Protection Screening and clinician responsiveness to Child Protection Alerts – ongoing
- Audits of Reports of Concern to CYF demonstrate that children are being referred appropriately – ongoing
- Results from an audit of disclosures of intimate partner violence in at least two primary care practices are shared with the Family Violence Steering Group by June 2017
- Implement the Wahine Ora (the vulnerable pregnant women's group) patient pathway by December 2016
- Audit the women receiving Wahine Ora planning and additional support services across Auckland and Waitemata DHBs to ensure the right women are receiving the services by December 2016
- Map the information sharing process between health professionals for child and family violence and identify areas of improvement by March 2017
- Audit to establish the child protection alerts are shared across primary, secondary and mental health services, to be completed by June 2017
- 'Sharing information' training is reviewed and strengthened by June 2017
- Review recommendations of the Family Violence Death Review Committee Fifth Report and other key reports, and consider implications for the DHB; the Family Violence Steering Group to report implications to the Executive Leadership Team by March 2017
- Develop a training programme for health professionals, including LMCs, primary care and Well Child Tamariki Ora providers to increase the confidence of providers to make routine enquiries regarding intimate partner violence by June 2017
- Results of quarterly audit of records of children aged 0–2 years accessing the Children's Emergency

Supporting Vulnerable Children

Department are monitored by the Family Violence Steering Group from November 2016

- Establish a working group for perinatal mental health with broad representation to develop population-level preventive approaches, early detection of perinatal mental health issues, develop referrals pathways, and develop primary perinatal mental health services – group established by August 2016
- Localise a pathway for key mental health risk factors (such as maternal depression) by June 2017
- Ensure a range of strength-based interventions is identified to support positive parenting and early attachment, with funding (for implementation in 2017/18) approved by February 2017.

Other actions

- Maintain Auckland DHB's Child Protection Policy and the CYF liaison social worker role – ongoing
- Build effective intersectoral working relationships, particularly with MSD and Education – ongoing.

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

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. Early intervention to appropriate services for those with mental health problems and substance abuse issues will positively impact health outcomes in young people. In 2016/17, our focus is to continue to enhance school-based health services and further develop youth primary mental health and drug and alcohol services.

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measures

- At least 95% of child and youth clients discharged from CAMHS and Altered High will have a transition (discharge) plan in place by December 2016
- 80% of 0–19 year olds referred for non-urgent mental health or addiction services are seen within three weeks and 95% within 8 weeks
- 95% Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) coverage in ESBHS.

Other measures

- 50+ young people and 50+ youth service providers to participate in the Look Up 2016 – Youth Innovation Forum
- Increase the number of CAMHS consult liaison contacts to 150 per quarter by June 2016 (baseline 129 per quarter)
- Altered High reporting across the region, by June 2016
  - At least 150 additional young people seen by Altered High
  - 15 Alcohol and other drugs (AOD) assessment and brief intervention training sessions provided to GPs, practice nurses, and school health services
  - 300 health professionals trained
  - 200 consultation/liaison contacts provided.

How will we achieve this?

- Maintain a high functioning Youth Service Alliance inclusive of clinical leadership, primary care and mental health providers – ongoing.

Enhanced school-based health service (ESBHS)

- Maintain high functioning school-based health services in all decile 1–3 schools, teen parent units and alternative education facilities – ongoing
- Maintain the visiting school psychologist programme, with clinical lead – ongoing

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

- Nurses to have Emergency contraception Programme (ECP) endorsement and use Standing Orders – ongoing
- Evaluate whether ESBHS is improving equity by assessing access breakdowns by ethnicity for Māori and Pacific by June 2017
- Ensure PDSA skills are maintained and applied in each school to continually improve service quality, as per each school's quality plan – ongoing
- Evaluate the effectiveness of the Alternative Education navigator role by June 2017.

Improve responsiveness of primary care to youth

- Continue to implement phase 2 of the Auckland DHB Youth SLAT work programme:
  - Obtain feedback from PHOs on the use of the College of GPs (CGP) accredited 'youth friendly' self-auditing tool by June 2017
  - Agree on how to standardise sexual health services, particularly in relation to access for young people not in education, employment or training (NEET) across primary care by December 2016.
  - Begin communicating best practice messages for primary care from Youth CGG by December 2016.

Child and adolescent mental health and youth alcohol and drug services

- Support the development of a youth peer support framework, to be developed by December 2016
- Ensure early communication and initial transitional engagement and planning for youth aged 12–19 years discharged from CAMHS and Altered High into primary care using MoH/Werry Centre guidelines – ongoing
- Deliver the 2016/17 youth-specific actions of the Auckland DHB Suicide Prevention and Postvention Action Plan (2015–17) by June 2017
- Altered High will continue to develop relationships and pathways through training and consult liaison sessions with primary care services (including PHOs, GPs, practice nurses and school-based health services) to improve the provision of alcohol and other drug (AOD) treatment for youth – ongoing
- Convene the 'Look Up Youth 2016 – Youth Innovation Forum' by December 2016.

Reducing Unintended Teenage Pregnancy *(Note: other activities related to this priority are included above)*

- Ensure all ESBHS staff are delivering a full range of sexual health services, including relationship advice from July 2017
- Evaluate whether ESBHS are reducing unintended teenage pregnancies by January 2017
- Engage Family Planning in the Youth Service Alliance Clinical Governance Group by September 2017
- Provide Sexual Health education programme for primary, secondary and tertiary care staff, including youth-friendly, culturally competent contraceptive choices, to be implemented from March 2017
- Develop regional clinical standards, protocols and clinical pathways for primary and secondary care and implement from November 2016
- Identify a DHB youth health/sexual and reproductive health clinical champion by December 2016.

Mental Health – Rising to the Challenge

Our population experiences more positive mental health than New Zealand as a whole. However, one in eight people living in our district experiences some form of mental illness, with 3.5% using secondary mental health services. Māori and Pacific individuals are particularly affected by mental health conditions. Not all waiting time targets (80% of people seen within 3 weeks, 95% within 8 weeks) have been met, with results under target for 0–19 year olds and 65+ year olds. Access rates for Māori youth reached 5.3% and 2.9% for youth overall. Access rates for older adults reached 3.0% and 3.6% for adults overall.

Rising to the Challenge

Health outcome: Reduce morbidity and mortality for people with mental illness

What are we aiming for in 2016/17? (Our measures)

Key measures

- At least 95% of child and youth clients discharged from community mental health and addiction services will have a transition (discharge) plan
- 80% of 0–19 year olds referred for non-urgent mental health or addiction services are seen within 3 weeks and 95% within 8 weeks.

Other measures

- Access targets for mental health and addiction services: 3.0% (5.6% for Māori) for 0- to 19-year-olds, 3.7% (10.0% for Māori) for 20- to 64-year-olds, and 3.1% for those aged 65+ years
- 95% of older adult service users meeting the criteria will have a current relapse prevention plan.

How will we achieve this?

Actively using our current resources more effectively

- Participate in regional plan activity – High and Complex needs, Eating Disorders, Substance Addiction (Compulsory Assessment and Treatment) Bill, Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and forensics (youth and adult) – ongoing
- Mental Health and Addictions NGO sustainability – with the Mental Health and Addictions sector NGOs and primary care, implement the agreed work plan and complete 2016/17 objectives by June 2017
- Utilising a co-design process develop a Shifting Services plan across DHB, primary care, Provider Arm and NGO services to deliver the right care, in the right place, at the right time, by the right people. Plan to be completed by June 2017, with full implementation by June 2018
- Continue to work collaboratively with Police to identify and implement initiatives that will improve the experience of people with mental distress who come to Police attention – ongoing
- Actively participate in the development of the Commissioning Framework and develop an implementation plan once the final Framework is published by June 2017 – ongoing.

Integration between primary and specialist services

- Plan and implement integration of General Practice and NGO support services based on the model(s) developed within the Tamaki Mental Health and Well-being Initiative.
- Stepped care model:
  - Pilot an alternative model of adult community mental health service working collaboratively with NGO(s) as part of the stepped care implementation by December 2016
  - Define and collect specific outcome measures by June 2017
- Build on primary and secondary integration by:
  - Ensuring community mental health clients enrolled with a GP have a discharge letter to the GP, and this includes physical health information – ongoing
  - Exploring the principles of practice to effectively operate clinical pathways across the primary/secondary continuum developed within the Tamaki Mental Health and Well-being Initiative by June 2017
- Trial first assessments in at least one GP practice for child and youth service users, evaluate for improved access by June 2017
- Mental Health Services for Older Adults and Health of Older People to continue roll out the Hospital Dementia Project. GP education CPD programme will be developed on the cognitive impairment pathway by June 2017.

Resilience and recovery

- Development of an Equally Well action plan for the Auckland and Waitemata DHBs to improve the physical health of service users. The initial stages of this plan will include the ability to record physical health status and development of baseline data, to be completed by June 2017

Rising to the Challenge

- Implement the priority actions identified from Everyone's Business: a mental health and employment strategy for the Auckland and Waitemata DHB regions by June 2017
- Develop a Supporting Parents Healthy Children (COPMIA) implementation plan for 'Essential Elements' of the Ministry guideline by June 2017
- Evaluate cultural competency of clinical staff working with Māori and CTOs (Section 29), identify gaps in current competency levels and make training recommendations June 2017
- Run focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommend steps for improvement by June 2017
- Implement new Eating Disorders Service Model by June 2017
- Deliver 2016/17 actions of the Auckland and Waitemata DHBs' Suicide Prevention and Postvention Action Plan (2015–2017). The plan and the actions will be guided by the Advisory Working Group and Inter-Agency Advisory Group, and will prioritise at-risk populations (e.g. youth/rural/Māori). Activities in 2016/17 will include developing community resources, wellbeing and resiliency; training community members and health providers to identify and support at risk individuals; and develop pathways between primary and secondary care providers – to be completed by June 2017
- Implement evaluation of local Infant and Perinatal metal health services – completed by March 2017.

Delivering increased access

- Continue roll out and training regarding the use of shared care plan to ensure that older adults who have been in the service for at least 2 years will have up-to-date relapse prevention plans – ongoing
- Complete the 2016/17 Mental Health Service for Older Persons Action Plan actions by June 2017
- Undertake a workforce skill mix review of workforce in Older Adult Services to enable increased productivity, particularly with respect to increasing access to initial assessment and entry to service by June 2017.

Health of Older People

By 2034 there will be around 96,000 people aged 65+ years living in our district, making up nearly 16% of the total population. Older people are large consumers of health care resources, currently occupying over 40% of our medical and surgical beds. Our aim is to ensure older people receive coordinated and responsive health and disability services that are accessible, flexible and timely. Integrating primary and community care across the health system enables patients to be treated closer to home, and with fewer acute and unplanned admissions into hospital.

Health of Older People

Health outcome: Older people experience independence and quality of life

What are we aiming for in 2016/17? (Our measures)

Key measures

- Reduce the percentage of people aged >75 years living in aged residential care (baseline 12% 2013/14)
- Monitor the percentage of people aged >75 years receiving Home Based Support Services (baseline 15.5% 2013/14).

Other measures

- System Integration: identify the number of direct referrals from community settings for rapid response
- interRAI Comprehensive Clinical Assessment
  - 100% of older people who have received long-term HCSS in the last three months have had an interRAI Home Care or a Contact assessment and completed care plan
  - The proportion of older people in ARC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of their previous assessment
  - 100% of LTCF clients admitted to an ARC facility have been assessed using an interRAI Home Care

Health of Older People

assessment tool in the six months prior to that first LTCF assessment
    - 90% of urgent referrals requiring an interRAI assessment are completed within 5 days and 90% of non-urgent referrals are completed within 15 days
- Falls Prevention and Fracture Liaison Service
    - total number of patients identified as having a fragility fracture
    - number of patients assessed by the FLS and the number commenced on therapy
    - 300 people receive strength and balance training
- Dementia Care Pathways
    - Cognitive Impairment Pathway report
    - number of GPs who have completed the e-learning resource
    - % of PNs per practice who have completed the e-learning resource
    - total number of patients started on the Cognitive Impairment Pathway
    - total number of new dementia diagnoses: 65–79 years; 80+ years
    - total number of new mild cognitive impairment diagnosis: 65–79 ears; 80+ years
    - ≥60 Auckland City Hospital staff trained as Dementia champions using Better Brain Care Pathway.

How will we achieve this?

System Integration

- Trial a strategic planning process for Health of Older people by 30 March 2017
- Implement the localities model to ensure effective wrap around services, including a single point of entry and single assessment tool for referrals – by June 2017
- Expand the rapid response service to allow direct access from community settings including ARRC and GPs – by December 2016
- Frailty pathway fully implemented by June 2017
- Investigate intermediate care models in the residential care setting – by December 2016
- Review processes to ensure the right health information is communicated between providers, including transfer of information between hospital and aged residential care (yellow envelope), and Home and Community Support Service providers and primary care and specialist services.

interRAI Comprehensive clinical assessment

- Continue to use interRAI assessment tools for all older people receiving long-term Home and Community Support Services (HCSS) or living in aged residential care (ARC) facilities – ongoing
- Ensure older people referred for an interRAI assessment to access publicly funded care services undergo the assessment and have a service allocated/declined in a timely manner – ongoing.
- Compare and benchmark performance with other DHBs and DHB regions using interRAI measures provided by the national data analysis and reporting (where there is a consistent approach to enable comparisons) to improve outcomes for older people – ongoing.

Home and community support services (HCSS)

- Support In between Settlement agreement outcomes (timeframe dependent on Settlement)
- HCSS procurement plan for new model of care approved by 30 June 2017.

Falls and fragility fracture prevention

- The joint Auckland and Waitemata DHBs and ACC Falls Working Group will, by September 2016:
    - develop a clinical pathway including: target groups, entry points and referral processes; a single entry point to coordinate service delivery; a range of services to meet different needs and follow up by 30 September 2016
    - undertake assessment of the capability and capacity of current service provision particularly community group provision of strength and balance training by 30 September 2016
    - identify and prioritise new service development and funding by 30 September 2016
    - complete a falls prevention business case.
- Maintain and monitor operations of the existing Fracture Liaison Service (FLS) – ongoing.

Health of Older People

Dementia care pathway

- Complete rollout of the 'living well with dementia model of care' to 50% of GPs with the electronic version of the Northern Region Cognitive Impairment Pathway by 30 June 2017 and the remaining 50% by 30 June 2018 (dependent on Board approval during 2015/16)
- All participating GPs and Practice Nurses will complete the eLearning Dementia Education Resource before going live with the 'Living well with dementia model of care'.

Implement the Kaumatua Action Plan

- Investigate the level of whānau carer stress; report completed by 30 March 2017.

Reducing health inequalities

We want to ensure that our Māori, Pacific, Asian, new migrant and refugee populations achieve the best possible health outcomes. Specifically, we aim to reduce the impact that known modifiable risk factors, including smoking and obesity, have on the health of these groups, identify and effectively manage chronic conditions (such as cardiovascular disease and diabetes), and ensure equitable access to culturally responsive health services.

Māori Health

Auckland's Māori population has higher rates of diabetes and cardiovascular disease and risk factors are more prevalent, particularly smoking, when compared with the overall Auckland population. Differences in health outcomes are best illustrated by the gap in life expectancy. In 2012–2014, Māori lived 5.2 years less on average. We have made positive gains for our Māori population; with a collective approach across the health system, we are determined to make further progress.

Māori Health

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measures

- Achieve ASH rate target of <4,955/100,000 population for Māori aged 45–64 years
- 80% of eligible Māori women received a three yearly cervical screen.

Other measures

- At least two Auckland DHB services implemented in the Glen Innes Whānau Ora Network
- 75% of Māori aged 65+ years of age will have received the seasonal influenza vaccine
- 70% of eligible Māori women have received a breast screen
- 95% Māori enrolment in PHOs
- Achieve asthma ASH rate target of <752/100,000 population for Māori aged 0–4 years.

How will we achieve this?

Priority areas of focus and performance measures are detailed in the 2016/17 Auckland DHB Māori Health Plan. These are:

- Data quality
- Access to health care
- Child health
- Cancer screening
- Smoking
- Immunisation
- Rheumatic fever
- Oral health
- Mental health
- Workforce
- Obesity
- Cardiovascular disease

Additional activity:

Provider development and service integration

- Continue to support the implementation and expansion of the Whānau Ora Network and model of care in Glen Innes in partnership with Ōrākei Health Services.

Pacific Health

Auckland's Pacific population has higher rates of diabetes and cardiovascular disease population and is over-represented in terms of risk factors, particularly smoking, when compared with other ethnicities. Differences in health outcomes are best illustrated by the gap in life expectancy. In 2012–2014, Pacific people lived 6.5 years less on average. Positive gains are being made for our Pacific population; with a collective approach from across the health system, we are determined to make further progress.

Pacific Health

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measure(s)

- Deliver 8 *Living Without Violence* programmes by 30 June 2017
- 85% of Pacific patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Other measures

- Deliver 10 *Incredible Years* and/or *PPP* parenting programmes by 30 June 2017
- Implement 2 Pacific-specific WERO quite smoke competitions by 30 June 2017
- Deliver 10 self-management education workshops by 30 June 2017
- 200 staff to participate in the Pacific Best Practice training
- DNA rates will be at 10%.

How will we achieve this?

These deliverables are part of the 2016/17 Pacific Health Plan:

Pacific children are safe and well and Pacific families are free of violence

- Participate in intersectoral family violence prevention forums – ongoing
- Increase Pacific engagement in the Family Violence Core training programme by providing ten Tautai Fakataha team presentations by June 2017
- Engage Pacific women and their families (by holding focus groups) in the co-design of maternity services by December 2016.

Pacific people are smoke-free

- Ensure that participating churches in the HVAZ programme remain smoke-free through an audit process by 30 June 2017
- Contribute to improving referrals to quit smoke services – ongoing.

Pacific people eat healthy and stay active

- Deliver nutrition education to the HVAZ programme with a stronger focus on childhood obesity, by including nutrition information for children by 30 June 2017
- Identify *Aiga* Challenge participants who sustain weight loss for 3 years and the causes for the weight loss by 31 December 2016, with analysis and reporting of the findings by 31 March 2017.

Pacific people seek medical and other help early

- In partnership with ARDS, develop and implement the Pacific Oral Health strategy; plan to be developed by June 2016 and implemented by June 2017
- Review parish community nursing service and refine scope of practice by June 2017.

Pacific people use hospital services when needed

- Produce Pacific video to support the DHB-wide patient experience video initiative by 30 June 2017
- Implement recommendations from review of Pacific cancer nursing service by 31 December 2016.

Pacific people live in warm houses that are not overcrowded

- Participate in MBIE-led process of seeking responses to Pacific people's housing needs – ongoing.

Asian, New Migrant and Refugee Health

The Asian population accounts for 31% of Auckland's population and is projected to increase over the coming years. Although our Asian population experiences the highest life expectancy in the district, Asian, new migrant and refugee populations are diverse and have specific health needs that require tailored and targeted health interventions and services. We aim to improve access to health services for these population groups and ensure they are culturally and linguistically responsive. This will assist with ensuring improved access and provide early opportunities for targeted intervention.

Asian, New Migrant and Refugee Health

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measures

- 90% of eligible Asians have had a heart and diabetes check in the last five years by June 2017, based on accurate ethnicity data collection and reporting protocols (Indian rate is 82% at January 2016)
- 95% of Asian children are fully immunised at 5 years of age by June 2017 (80% as at January 2016)
- Increase cervical screening coverage rate to ≥80% by 2020 (65.5% as at November 2015).

Other measure

- Three refugee forums delivered to primary health professionals across Auckland and Waitemata DHBs, and engage Counties Manukau DHB by June 2017.

How will we achieve this?

Ethnicity Data Quality

- Establish complete and accurate data on level 2 ethnic groups to guide planning and monitoring of services – June 2017.

Long-Term Conditions

- Continue to perform More Heart and Diabetes Checks to Asian populations with a focus on eligible Indian males (35–44 years)
  - Increase culturally appropriate communication to South Asian and other targeted ethnic groups - June 2017.

Childhood Obesity

- Work with Asian service providers to monitor the number of pregnant women engaged with the HBHF programme with healthy weight gain in pregnancy by June 2017
- Provide culturally appropriate Asian & MELAA breastfeeding support in the development of a suite of strategies including peer support training, health professional health literacy (primary care, LMCs and community workers) and increased resourcing of information via the Pregnancy and Parenting app and website – June 2017.

Immunisation

- Promote awareness of the prevalence of measles and uptake of the 4-year immunisations event in Asian communities – by June 2017.

Women's Health

- Continue to provide free smears for Asian women aged 30–69 years who have not been screened or are under screened in the last 5 years – ongoing.

Mental Health

- Maungakiekie/Tamaki locality – Mental Health and Wellbeing principles of practice developed with peoples from Asian, refugee and CALD migrant backgrounds and implemented by June 2017.

Refugee Health

- Provide workforce development training to primary health professionals on refugee health by June 2017.

World-class Healthcare

We need to provide reliable, safe and high quality care for our patients. The hospital needs to run more efficiently with more consistent service across the whole week. Patients expect to manage their own health, to determine the care they want, and how it is delivered. Models of care need to be designed around the patient, so they can access the services they need in the right place.

Our goal is to:	Provide rapid access to world-class healthcare that is equitable, high quality and safe

Rapid access to health services

Access to the right care at the right time in the right location is critical in providing the best care possible. Patients want certainty regarding access to health care when they need it, without long waits for their assessment, diagnosis or treatment.

Shorter Stays in Emergency Departments

Approximately one in seven of our population visited a hospital Emergency Department (ED) last year, this demand has risen by nearly 60% in six years (HNA, 2015). Currently, 95% of ED patients spend no longer than six hours in the ED. Shorter stays in the ED result in less overcrowding, better health outcomes and shorter hospital stays, enabling us to use our resources more effectively and efficiently.

Shorter Stays in Emergency Departments

Health outcome: Our population live longer, healthier and more independent lives

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Health Target: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours of presentation (including by ethnicity).

How will we achieve this?

Acute demand

- Analyse ED attendance data to build profile of attenders and disease groups with options to reduce avoidable attendances – report to inform quality improvement/service redesign developments to be compiled by December 2016
- Explore potential of a primary unit within ED (Nurse Practitioner, Community Pharmacy) as alternative for low acuity attendances – prepare paper on recommendations by December 2016
- Explore systems to support people in their own homes, linked with Rapid Response Teams, St Johns, GPs, Aged Residential Care, Chronic Disease, providing input to developments led by Adult Community and Long Term Conditions Service – by December 2016
- Promote health literacy and use of non-ED services available via Health point – by September 2016.
- Explore Tele health options such as symptom checkers, self-care/management and information on triage, to prevent ED presentations and re-presentations for minor ailments. Collate in a paper re options for implementation by June 2017
- Support Healthy Auckland working with ARPHS to reduce harm from alcohol and drugs in 2016/17.

Managing acute flow in ED

- Implement work programme to improve flow – redesign and model of care, including pathway development (for chest pain, frailty, fracture), by June 2017
- Accelerated chest pain pathway – audits of all ED discharged patients for adverse event rates, representation rates, referral rates and time to cardiology follow-up – 6 monthly
- Examine staff mix within ED workforce – seek to have right skills in the right place at the right time, improving capacity within budget, and documented in a workforce plan by December 2016
- Improve timely access to diagnostics and validation using transparent pathways and quality

Shorter Stays in Emergency Departments

improvement initiatives by December 2016

- Reduce duplication in data gathering in ED by improving communication mechanisms to minimise questioning yet collect and use the information needed (quality improvement initiative) by December 2016
- Implement interventions in ED to reduce alcohol, drug and smoking related attendances that include sign-posting to appropriate services for intervention by December 2016
- Improve the timeliness for review for Mental health patients (within ED target) including implementing the ED Police pathway by June 2017
- Report SSED target performance by ethnicity from July 2016
- Fully implemented ED Quality framework:
  - Monthly reporting of quality metrics for data electronically captured
  - Annual audit of all other metrics.

Managing outflow

- Ensure early access to inpatient specialists in the ED through agreed pathway development and collaboration with different specialties by June 2017
- Support and provide input to the development of 24/7 service response in Adult Community and Long Term Conditions Service by June 2017
- Communicate pathways and transitions out of ED more explicitly to other stakeholders, supported by pathway documentation and discharge summaries that makes clear who will be involved in care provision in the community particularly for vulnerable groups (e.g. those with no fixed abode, refugees, migrants, mental health clients) by December 2016
- Use the locality model being introduced in Auckland DHB services as a way of connecting, collaborating and sharing information – embed as business as usual by December 2016.

Improved Access to Elective Surgery

Providing our population with timely and equitable access to elective surgery is a key priority. Compared with the New Zealand average, Auckland DHB residents have a lower rate of access to elective surgery, such as hip and knee replacements, angioplasties and angiographies. We also provide elective heart operations for Waitemata and Counties Manukau DHB residents.

Improved Access to Elective Surgery

Health outcome: Our population live longer, healthier and more independent lives

What are we aiming for in 2016/17? (Our measures)

Key measure

- Delivery against the agreed volume schedule, including at least 17,230 elective surgical discharges in 2016/17 towards the Electives Health Target and at least 130 elective orthopaedic and general surgery discharges in 2016/17, as part of the Budget 2015 additional investment.

Other measures

- Achieve an elective surgical inpatient standardised ALOS of 1.55 days
- Standardised Intervention Rate targets:
  - Major joint replacement procedures: a target of 21 per 10,000 of population will be achieved
  - Cataract procedures: a target of 27 per 10,000 of population will be achieved
- Patients wait no longer than four months for first specialist assessment and treatment
- All patients are prioritised using the most recent national tool available
- Patient level data is being reported in the National Patient Flow (NPF) collection, in line with specified requirements
- Deliver at least 43 bariatric surgeries by June 2017.

Improved Access to Elective Surgery

How will we achieve this?

Elective Surgery

- Undertake project to understand elective demand and capacity requirements at sub-specialty level – by Q2
- Monthly and weekly production planning processes to continue in each directorate. This focus on patient flow management (outpatient clinics, procedures and inpatient lists) will continue to maintain reduced waiting times for electives – ongoing
- Implement standardised regimes involving GPs for patients requiring ongoing follow-up for access to primary/secondary care/tests (e.g. cancer survivorship strategies, "see and treat") to free up specialist resources for surgical elective – by Q3
- Undertake bed planning to ensure elective capacity is maintained over the winter period – winter bed plan in place by Q1
- Implement use of ERAS ward for orthopaedics to sustain reduced length of stay (LOS) for specific conditions (THJR & TKJR) – by Q3
- Continue involvement in the joint Auckland/Waitemata DHB bariatric surgery project to further develop equitable access to bariatric surgery for all Auckland DHB population – by Q4
- Implement national Clinical Prioritisation Access Criteria (CPAC) tools as they become available and explore ways to share information and feedback with primary care regarding CPAC scoring to increase understanding and improve quality and appropriateness of referrals – ongoing
- Participate in all phases of National Patient Flow (NPF), including identification of, and engagement with, local, regional and sector-wide quality improvement opportunities – ongoing

Major Trauma

- Continue to submit data to the National Trauma Registry – ongoing

Improved Access to Diagnostics

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Currently, 100% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks, 99% of accepted referrals for elective coronary angiography receive their procedure within 3 months, and 96% of accepted referrals for CT scans and 52% of accepted referrals for MRI scans receive their scan within six weeks.

Improved Access to Diagnostics

Health outcome: The lowest premature mortality from cancer

What are we aiming for in 2016/17? (Our measures)

Key measure

- Achieve Faster Cancer Treatment specific targets, 7 days for CT and 10 days for MRI.

Other measures

- Radiology
  - Reduce inappropriate and increase appropriate community-referred radiology referrals by Q3
  - 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)
- Pathology
  - Improve turnaround times for Laboratories and Pathology from current 7-day baseline
- Diagnostic colonoscopy
  - 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
  - 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days
- Surveillance colonoscopy

Improved Access to Diagnostics

- 70% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100 percent within 120 days.

Note: Measures related to improving radiology services appear in the Service Configuration section within this module.

How will we achieve this?

Achieve identified waiting time targets by:

- Participate in activity relating to implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to NPF as required – ongoing
- Work with regional and national clinical groups to contribute to development of improvement programmes – ongoing.

Radiology

- Continue with National Service Improvement actions, including maintaining Greenlane radiology facilities as the Auckland DHB centre of excellence and extension of radiology hours to 40-hour week, with all new staff employed from Q1 on a 40-hour week contract – ongoing
- Investigate opportunities and make recommendations to the Board to use regional radiology capacity, including mobile facilities, to provide access to community-referred radiology, especially ultrasound, to increase internal DHB capacity for access to diagnostics for ED and acute admissions by Q3
- Standardise protocols across ultrasound, CT and MRI scanners locally and regionally by December 2016
- Optimise Radiology throughput at Starship Hospital to maximise paediatric anaesthetist availability by September 2016
- Continue with additional weekend sessions for MRI and ultrasound to achieve waiting times targets by December 2016.

Colonoscopy/Endoscopy

- Identify and implement ongoing actions to improve waiting times and quality of colonoscopy/endoscopy services, including:
  - Support greater training and support of the workforce with implementation of nurse endoscopists from Q1
  - Undertake regional collaboration to improve access and timeliness to colonoscopy procedures through the Regional Colonoscopy Network – ongoing monthly meetings
  - Implement regional standardised triage processes for surgical and medical colonoscopy referrals to reduce variation across the region by Q3.

Laboratory/Pathology

- Improve Laboratories and Pathology testing turnaround times in line with regional initiatives – Q4.

Note: Deliverables related to improving radiology services appear in the Service Configuration section within this module.

High quality, safe, dependable services

We aim to deliver timely, world-class healthcare and disability services to our population. To achieve this we need to ensure that people trust our services. Our practices must be reflective, ensuring continuous improvement with staff that are mindful and learn from peers and colleagues.

Living Well with Diabetes

Diabetes exacerbates the burden of many diseases, including CVD. With an estimated prevalence of 4.6% (age-standardised prevalence, NZHS) and rising, diabetes will significantly impact future health outcomes.

Living Well with Diabetes

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- 3% reduction in proportion of patients with HbA1c above 64, 80 and 100 mmol/mol at their annual review.

Other measure

- Percentage of newly diagnosed people with type 2 diabetes who are referred to DSME within a year of diagnosis
- Percentage of patients with type 2 diabetes referred to and accessed DSME.

How will we achieve this?

Diabetes Service Alliance Work Programme

- Complete the development of the Work Programme as approved by the Alliance Leadership Team by June 2017, covering the following workstreams:
  - Systems Redesign
  - Optimisation of Clinical Management
  - Self-Management Education and Support, including DSME and Care Planning
  - Workforce Development
- Develop a Diabetes Model of Care, guided by the MoH Quality Standards for diabetes care, that is fit for purpose, informed by evidence and patient/provider experience, and adopts a whole-of-systems approach to better align services across Auckland and Waitemata DHBs by June 2017
- Develop an implementation plan for the Diabetes Model of Care by June 2017.

Enable effective self-management

- Undertake a co-design process involving patients and their family and whānau and providers to identify factors that affect access, utilisation and effectiveness by December 2016
- Develop a DSME Service Delivery Model including a model specific to Māori and Pacific that will improve access and utilisation by June 2017
- Support the implementation of the Northern Region Diabetes Network (NDRN) Standards for DSME and audit DSME programmes against the standards by June 2017.

Optimise clinical management including care planning to improve quality of services

- Implement systems and processes to measure and monitor the regionally agreed clinical indicators to help improve outcomes by June 2017
- Commence the implementation of the Diabetes Pathway by June 2017
- Develop a Care Planning template to standardise data collection of patient outcome measures across the Northern region DHBs by June 2017
- Evaluate the West Auckland quality improvement pilot by June 2017
- Collect the minimum dataset for people with type 2 diabetes by June 2017
- Develop strategies to improve secondary diabetes services DNA rates, particularly in high needs patients, as part of the Service Alliance Work Programme by June 2017.

Living Well with Diabetes

Early detection to reduce risk of complications

- Review of the retinal screening service and develop an action plan to ensure that all patients with diabetes have access to retinal screening assessment in line with the Ministry's guidelines by June 2017
- Review the podiatry service and develop an action plan to ensure that all people with diabetes have a comprehensive foot assessment annually by June 2017
- Track and measure the incidence of diabetes-related amputations, particularly in Māori by June 2017 with a long-term goal of reducing incidence.

Provide integrated care including workforce development

- Improve primary care providers' access to specialist diabetes service for advice, education and mentoring by June 2017
- Develop standard referral criteria to optimise appropriate referrals and utilisation of specialist service by patients with diabetes by June 2017
- Develop a diabetes/CVD education programme for primary health care nurses, based on the National Diabetes Knowledge and Skills Framework by June 2017.

Budget 2013 funding

- Continue to deliver podiatry services funded through budget 2013 in select practices to agreed volumes (1,683) for 2016/17
- Provide a report to the Ministry on the programme for the 2015/16 year by Q1 2016/17

Note: Deliverables related to preventing high risk people from developing type 2 diabetes appear in the Obesity, Improved Access to Elective Surgery and Cardiovascular Disease (CVD) sections within this module. Related measures also appear in the CVD section.

Cardiovascular Disease (CVD)

Despite having some of the lowest mortality rates from CVD (104.7 per 100,000 individuals) in the country, CVD is still a leading cause of premature mortality in Auckland. Early identification of those most at risk, comprehensive lifestyle advice and early treatment can prevent the development and/or progression of CVD. Currently, 92% of the eligible population have their CVD risk assessed within 5 years, and 54% are on triple therapy; the Northern Region's aspirational target is 70%.

Cardiovascular Disease (CVD)

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- 90% of the eligible population will have had their cardiovascular risk assessed in the last five years (by ethnicity – Māori, Pacific Indian and Asian).

Other measures

- 70% percent of patients with known cardiovascular disease who are on triple therapy
- Percentage of patients with 5-year cardiovascular risk ever recorded >20%, who are on dual therapy.

How will we achieve this?

Prevention

- PHOs will continue to work with general practices to ensure patients are provided with relevant resources by the practice – ongoing
- PHOs will continue to work with general practices to ensure patients, especially Māori and Pacific patients, are referred to exercise and nutrition programmes – ongoing.

Early Detection

- Fund primary care to provide More Heart and Diabetes Checks to eligible populations – ongoing.

Cardiovascular Disease (CVD)

Optimise Clinical Management including Care Planning to improve quality of services

- Report on the regionally agreed diabetes/cardiovascular disease clinical indicators and establish baseline data by June 2017
- Use this information to feedback on clinical indicator performance at practice level and support practices to improve management of CVD (particularly for high risk populations) by June 2017
- Develop a consistent Care Planning template for use in the Northern region by June 2017.

Note: related deliverables appear in the Tobacco, Obesity and Living Well with Diabetes sections within this module.

Cardiac Services

Health outcomes can be improved through ensuring a nationally consistent approach to Acute Coronary Syndrome (ACS) risk stratification and timely access to appropriate intervention for cardiac patients. Currently, 91% of patients receive an angiogram within 3 days of admission and 5.73 cardiac operations are performed per 10,000 of the population (standardised). In 2014/15, 540 people received coronary revascularisations to treat their cardiac conditions, resulting in 840 quality-adjusted life years (QALYs) gained by our population.

Cardiac Services

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- Maintain at least 70% of ACS inpatients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') by ethnicity (baseline = 89.3%, Q2 2015/16).

Other measure

- Deliver 267 total cardiac surgery discharges
- 95% of people will receive elective coronary angiograms within 90 days
- No patients will wait longer than four months for first specialist assessment and treatment
- The waiting list for cardiac surgery remains between 5 and 7.5 percent of annual cardiac throughput, and does not exceed 10 percent of annual throughput
- Cardiac surgery patients are operated on within nationally agreed urgency timeframes
- Improve cardiac rehabilitation programme retention rates to 85% by December 2016
- 95% of outpatient echocardiograms to be completed within 3 months of referral
- Standardised intervention rates
  - Cardiac surgery: target intervention rate of 6.5 per 10,000 of population
  - Percutaneous revascularisation: target rate of at least 12.5 per 10,000 of population
  - Coronary angiography: target rate of at least 34.75 per 10,000 of population.

How will we achieve this?

- Refine acute patient flow transfer processes for patients meeting Priority 1 wait time – ongoing
- Escalation plan in place to manage cardiac surgery waiting list – to be implemented as required
- Monitoring of CPAC tool use to ensure consistent application – ongoing
- Implement all outcomes from audit activities of cardiac rehabilitation services undertaken in 2015/16 to improve retention rates and align cardiac rehabilitation activities to the locality-based model of care developed by Community and Long-Term Conditions Directorate by June 2017
- Continue to work on improving systems for data input and recording for cardiac surgery and cardiology registry data, and meet national targets consistently by July 2017; new dedicated resource to coordinate completion in place by Q1; audit of current processes for registry data collection including gap analysis undertaken by Q2; improvement process based on audit findings completed by Q3

Cardiac Services

- Regional participation in the development of a capacity workforce and plan for Electrophysiology, arrhythmia and pacing for the medium to long-term, with the plan to be completed by June 2017
- Improve access to Echo to support diagnosis of heart failure and other conditions, including those requiring cardiac surgery – model of care change to be implemented by December 2016
- Work with Māori Health team to identify cohort of cardiac patients with comorbidities where DNA rates are high to reduce DNA rate gap between Māori and non-Māori – cohort identified by December 2016, strategies to address DNA rates agreed by June 2017.

Stroke Services

Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Patient outcomes are improved when care is provided through an organised acute stroke service as recommended in the New Zealand Clinical Guidelines for Stroke Management. Presently, 86% of our admitted stroke patients were treated via a documented stroke pathway, and 10.8% of our eligible stroke patients are thrombolysed.

Stroke Services

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- At least 10% of potentially eligible stroke patients are thrombolysed 24/7.

Other measures

- 80% of stroke patients admitted to a stroke unit or organised stroke service
- 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report percentage of acute stroke patients transferred to inpatient rehabilitation).

How will we achieve this?

- Develop and deliver a regional plan for stroke services, including local components (consistent with the New Zealand Clinical Guidelines for Stroke Management 2010 – the Stroke Guidelines) to support continued implementation of best practice stroke care and provide equitable access. This will cover: stroke unit/organised stroke service access, 24/7 thrombolysis access, door to needle time, early rehabilitation services, education, training and audit of interdisciplinary stroke team, workforce and education programme, ethnic disparities and information management requirements – develop and commence implementation by December 2016
- Develop a business case for a clot retrieval service as part of a Hyper-acute pathway at Auckland DHB as part of a regional Hyperacute pathway by December 2016
- Progress the next phase of implementation of a re-designed responsive all-age stroke rehabilitation interdisciplinary service by June 2017
- Support the national rollout of the FAST campaign through regional collaboration over 2016/17
- Participate in national and regional stroke networks, quality improvement and monitoring – ongoing
- Agree a DHB approach for risk recognition, early detection and prevention linked to the organisational Smokefree plan during 2016/17.

Cancer

Despite having one of the lowest mortality rates from cancer (110.6 per 100,000 individuals) in the country, more than one in every four deaths is attributable to cancer, significantly contributing to ethnic differences in health outcomes. At present, 69% of our patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks (the national target is 85%).

Cancer

Health outcome: The lowest premature mortality from cancer

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Health Target: 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Other measures

- 90% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat by June 2017
- 100% of patients will receive their radiotherapy and chemotherapy within 4 weeks of decision to treat every month
- 70% of patients waiting for a surveillance colonoscopy will wait no longer than 84 days, 100% within 120 days
- All cancer-related MDMs to use electronic forms to document MDM outcomes by June 2017
- All urgent diagnostic bowel investigations will be completed within two weeks.

How will we achieve this?

- Audit two tumour specialities for appropriate application of the high suspicion cancer flags (to increase identification of these patients) consistent with regional processes by December 2016
- Educate medical staff on using high suspicion cancer flags for communication and orientation – ongoing
- Identify the percentage of patients who fit the criteria of high suspicion cancer who access their treatment in the private sector by June 2017
- Identify the ethnicity-specific high suspicion cancer conversion rate by June 2017
- Localise and implement the prostate pathway in primary care by June 2017 (consistent with the Ministry of Health's Prostate Cancer Management and Referral Guidelines)
- Continue to contribute to the prevention and early detection of cancer through our other programmes, including healthy lifestyles (in particular obesity, alcohol and tobacco), breast screening, cervical screening and bowel screening – ongoing.

Improving Quality

Patient safety is the cornerstone of high quality health care. Our performance within the key quality and safety markers has improved and we aim to continue this progress. Our rates of compliance with good hand hygiene practice has improved from 70% (July–October 2012) to 81% (July–October 2015). The rate of central line infections remains low, at below 0.5 per 1,000 central line days in all of our intensive care units. Since improving our data capture quality in 2012, we continue to maintain a low number of patient falls resulting in major harm to <1 per 10,000 bed days. This strong result is partly due to 93% of elderly patients being assessed for their risk of falling and those at risk having a falls care plan in place.

Improving Quality

Health outcome: Patients stay safe in our hospitals

What are we aiming for in 2016/17? (Our measures)

Key measure

- ≥80% compliance with good hand hygiene practice.

Other measures

- Reducing nosocomial infection
  - CLAB – insertion compliance at >90% and our rate at <1/1000 days (in all areas)
- Reducing harm from falls
  - 93% of older patients are given a falls risk assessment

Improving Quality

- 98% of older patients at high risk of falls receive an individualised care plan addressing their risks

- Safe surgery
  - 95% of hip and knee replacement patients receive 1.5 g or more of cefazolin or 1.5 g or more cefuroxime
  - All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100% of audited surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95% of the time
  - All three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90% of operations
  - Antimicrobial timing – 100% of hip and knee replacement patients receive prophylactic antibiotic 0–60 minutes before incision
  - Correct duration – prophylaxis is discontinued within 24 hours of surgery on 98% of hip and knee replacement patients and within 48 hours for 100% of cardiac patients
  - Appropriate skin antisepsis – 100% of hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine
  - For cardiac surgery 96% of patients received cefazolin ≥2g as surgical prophylaxis
  - 93% of cardiac patients received surgical prophylaxis on time
  - Appropriate skin antisepsis – 99% of cardiac patients had recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine
- Reducing harm from VTE
  - 90% of adult inpatients have documented VTE risk assessment
- Reporting performance
  - Updates published by the Health Quality & Safety Commission will be included in Auckland DHB's quality accounts and reported to clinical board and HAC
- Pressure injury prevention
  - 100% of Grade 2, 3 and 4 notified nosocomial pressure injuries receive an ACC45 and ACC2152.

How will we achieve this?

Hand hygiene

- All clinical areas will maintain gold auditors for hand hygiene compliance and undertake real-time monthly auditing and reporting to ensure ownership and opportunity to recognise great hand hygiene techniques and moments – ongoing
- Continue bi-monthly gold auditor education and training (at least two per ward), reminders in the workplace (e.g. the 'Take a Moment' behavioural project) and goal setting to achieve ownership and accountability at ward level to ensure programme sustainability – ongoing
- Monthly reports of the number of moments audited and the compliance rates for each ward will continue to be presented at the Infection Prevention and Control Committee and MOS to maintain focus – ongoing.

Reducing nosocomial infection

- Establish a process to commence monitoring short-term central line insertion compliance and infection rates in areas beyond ICU (e.g. renal, haematology and general surgery) by December 2016.

Reducing harm from falls

- Revise the process for serious harms investigation and continue reporting to the adverse event review sub-committee and identify areas for improvement – ongoing
- Falls risk assessment and care planning is audited monthly with results reported by ward/department through the use of pareto charts – ongoing
- Rollout the falls module of accelerated Releasing Time to Care toolshed to four more wards by December 2016.

Safe surgery

- Undertake monthly observational audits of the use of the paperless surgical safety checklist by each speciality group to ensure the its use as a teamwork and communication tool – ongoing

Improving Quality

- Introduce direct observational audit for each operating theatre list to improve patient safety, teamwork and communication within the teams – ongoing
- Work with the Commission to implement briefing and debriefing for theatre lists – ongoing
- Work with the Health Quality and Safety Commission (HQSC) to implement the new perioperative harm quality and safety marker for public reporting in 2016/17
- Work with the Anaesthetic Department to improve adherence to SSIIP prophylactic antibiotic (cefazolin) protocols and ensure that private providers performing DHB-funded surgery in the private sector also adhere to the protocols – ongoing
- Continue to audit the appropriate dose and timing of administering cefazolin and appropriate skin preparation for hip, knee and cardiothoracic surgery, and track and report the results – ongoing
- Extend SSI surveillance for cardiothoracic surgery procedures over 2016/17.

Medication safety

- Rollout medicines reconciliation across agreed pilot wards; implementation to be completed for ED/APU and 2 OPH wards by September 2016, with further evaluation and recommendations to be made for further deployment post pilot wards
- Introduce electronic prescribing and administration – develop a business plan and implement in two wards by July 2016
- Continue to actively participate in the National Opioid Collaborative – ongoing.

Reducing harm from VTE

- Complete the rollout of the VTE risk assessment tool for adult inpatients by June 2017.

Pressure injury prevention

- Monitor completion rates of ACC45 and ACC2152 reporting – ongoing
- Identify and report to HQSC all pressure injuries Grade 3+ as serious adverse events – ongoing
- Consistently measure pressure injury prevalence monthly and report organisation-wide at Directorate and Ward levels – ongoing
- Ensure the all major harm pressure injuries are reported in risk monitoring systems and investigations completed by comparing with coded data – ongoing
- Review current risk assessment and prevention process for improvement opportunities – ongoing
- Establish the Pressure Injury Concept Ward and test bed for new ideas/initiatives by December 2016.

Build quality improvement capability and clinical leadership

- A new quality IT system to support our patient safety and clinical governance activities, with implementation to commence July 2016
- Use data to continue to develop new reports that enable better understanding and clarity of trends in organisational risks – ongoing
- Offer Improvement Fundamentals and Improvement Practitioner training programmes to all Auckland DHB staff – ongoing.

Other actions

- Actively participate in the national HQSC Open for Better Care campaign – ongoing
- Work with ACC to trial a community-based falls programme aimed at preventing falls related admissions to the hospital system by December 2016
- Work collaboratively with ACC and Waitemata DHB to trial the effectiveness of Strength and Balance exercises delivered in a community setting (often the patient's home) by June 2017
- Complete the annual quality accounts work.

Note: Deliverables related to patient experience appear in the Patient Experience and Community Participation section within this module.

Achieved Together

People are at the centre of our work. Health workers need to understand what matters for our communities, groups facing disadvantage and inequity, families and whānau, and every patient who needs help. Our approach is to empower people to be active in their communities as well as active partners in health and healthcare decisions. Services and care plans will be tailored to the individual and oriented to the things that matter. All of our interactions are underpinned by a respect for cultural differences. Having a set of shared values builds a common understanding of what this looks like in practice.

Our goal is to:	Work as active partners across the whole health system, including staff, patients whānau, iwi, communities and others

Patient Experience and Community Participation

Patient experience is an important indicator in assessing the quality of care provided and is strongly linked to overall health outcomes. Our focus is on individualised care and tailoring services to meet patient and whānau needs, and engaging patients as partners in their care. An enhanced patient experience leads to better emotional health, symptom resolution, less reported pain and more effective self-management.

Working in partnership with our communities results in services, activities and programmes that reflect the strengths, needs and resources of our patients, families and the wider community, and outcomes that are understandable and reflect their expectations.

Patient Experience and Community Participation

Health outcome: Engage patients and communities in the care they receive

What are we aiming for in 2016/17? (Our measures)

Key measures

- Improve patient experience as indicated by our key benchmark measures of 45% of inpatient respondents and 53% of outpatient respondents rating their experience of care as 'excellent' (September 2014)
- All stakeholders and community participants rate Auckland DHB as a 'highly trusted' partner in the Tamaki mental health and wellbeing prototype process ('highly trusted' is defined as 80% of community participants rate Auckland DHB at 4 or more out of 5 on a trust measurement scale co-designed with our community partners).

Other measures

- Consumer representatives in place in all Auckland DHB directorates by June 2017
- Recruit 500 new Reo Ora Health Voice online community panel members by June 2017
- Establish the baseline for patient email address collection by June 2016 and increase by 25% by June 2017
- Quarterly reporting on patient experience (national patient experience survey data).

How will we achieve this?

- Finalise a Participation and Experience Plan by December 2016
- In partnership with health and social sector community stakeholders, develop and refine the service innovations being trialled to improve mental health and wellbeing in the Tamaki area – ongoing
- Implement improved look and feel and functions for the Reo Ora Health Voice online community web-platform – by June 2017
- Extend the Patient Experience Survey to two more outpatient services and the Adult Emergency Department by June 2017
- Train 20 more service leaders on how to access the Patient Experience Survey feedback portal by June 2017
- Develop processes to better integrate patient, whānau and community feedback into service improvement and staff development and training by June 2017
- Confirm and implement the 24/7 patient support person visiting policy by December 2016

Patient Experience and Community Participation

- Roll out the 'Companion Volunteer' position, being trialled in Women's Health and Reablement Services by December 2016
- Call for concern (i.e. Ryan's Rule; a patient/family escalation process) in trial phase by June 2017
- Care Escalation Plans in trial phase by June 2017
- Establish clear information and processes for consumer representation on project and management teams across the organisation by June 2017
- Consumer and community representative documentation, support and training processes in place by June 2017.

Whānau Ora

DHBs have a role in contributing to achieving Whānau Ora and health equity across the whole of the health system, actively engaging and collaborating with Commissioning Agencies to benefit the health of whānau. In 2016/17, our focus will be on achieving accelerated progress towards health equity for Māori and Pacific, and Whānau Ora in the next four years in five key areas – mental health, asthma, oral health, obesity and tobacco. More details can be found in our Māori Health Plan.

Whānau Ora

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measures

- Decrease the rate of Māori treatment orders made under section 29 of the Mental Health Act (258 per 100,000 individuals aged 15+ years, Auckland DHB 2012/13 financial year)
- 95% of Māori pre-school children enrolled in the Community Oral Health Service at December 2016.

Other measures

- Increase in the number of Māori children who are caries free at age 5
- 80% of all new-borns are enrolled with a GP, in NIR, WCTO, Community Oral Health and hearing screening in the first 3 months by Q4 as part of the Single Enrolment Project
- Achieve asthma ASH rate target of <752/100,000 population for Māori aged 0–4 years
- By December 2017, 95 percent of obese Māori children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions
- 95% of all pregnant Māori women smoke free at two weeks post-natal.

How will we achieve this?

Specific deliverables or actions to improve performance include:

- Work with Te Pou Matakana and Te Runanga o Ngāti Whātua to identify and implement opportunities for co-investment and service co-design to support improved outcomes in more than one of the key Whānau Ora areas – ongoing
- Collaborate with Te Pou Matakana to contribute to the Tamaki Collective Impact initiative, with a focus on improving health literacy in whānau to reduce obesity – ongoing
- Strengthen our relationship with Te Pou Matakana through quarterly meetings to provide updates on planning and commissioning activities, and to identify opportunities for joint activities that will benefit whānau – ongoing
- Identify at least one commissioning priority to support improved outcomes in at least one key Whānau Ora area that Auckland DHB and Te Pou Matakana can investigate a joint commissioning project that will benefit whānau by December 2016
- Present at least one joint commissioning activity to the Auckland DHB Board to support improved outcomes in at least one key Whānau Ora area for consideration by June 2017
- Continue to maintain a strategic relationship with Pasifika futures to discuss opportunities to work together - ongoing.

Whānau Ora

Mental Health

- Audit clinical-cultural care pathway for Māori in Auckland DHB mainstream services under compulsory community treatment orders and report on improvement recommendations by June 2017
- Evaluate cultural competency of clinical staff working with Māori and CTOs (Section 29), identify gaps in current competency levels, and give recommendation of any training required by June 2017
- Run focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommended steps for improvement by June 2017

Asthma

- Audit the primary care component of the asthma care pathway by March 2017, and implement interventions(s) based on the audit findings by June 2017
- Develop a mechanism to monitor if Māori children who are receiving asthma support services are presenting to ED as ASH admissions by June 2017
- Audit the use of the asthma action plan in primary care and secondary care by December 2016 and implement intervention(s) accordingly by June 2017.

Oral Health

- Finalise ARDS Preschool strategy to improve Māori pre-school children enrolment and utilisation in community oral health services by October 2017
- Implement the ARDS preschool and adolescent strategy December 2016.

Note: related deliverables appear in the Tobacco and Obesity sections within this module.

Working as One System

Our hospital services must be sustainable over time. Our funding has to go further. This requires us to get even more value from our staff and resources, to reduce clinical and financial risk by providing sustainable, cost-effective services at regional and sub-regional levels. It also involves re-thinking care delivery models, designing care around the patient and shifting services to community care settings, where this has the greatest benefit.

Service Configuration including Shifting Services

A more integrated system where primary and secondary care clinicians work collaboratively with clear and open lines of communication will ensure that appropriate healthcare services are delivered in the right place at the right time. We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, including shifting services, to ensure patients receive more effective and co-ordinated services closer to home and provided by one team.

Service Configuration, including Shifting Services and System Level Outcome Measures

Health outcome: Patients receive more effective and co-ordinated services closer to home and provided by one team

What are we aiming for in 2016/17? (Our measures)

Key measures

- System Level Outcome measures (as set out in the Outcomes Framework in Module 1)
- 10 additional general practices are participating in the Safety in Practice programme
- Maintain direct access (baseline = 22,817 community referrals – 2015/16) for general practitioners to a full suite of diagnostic imaging including x-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI with a focus on managing to appropriate waiting times – ongoing
- Primary Options for Acute Care (POAC) target – 7,000 referrals.

Service Configuration, including Shifting Services and System Level Outcome Measures

How will we achieve this?

Collaboration

- Implement Stage One of the Palliative Care Lead Provider model by 30 September 2016
- Continue to work with PHOs to develop the HealthCare Home
    - Progress discussions to define model and level of investment Q1-Q2
    - Determine final model Q3
    - Determine level of investment Q3
- Develop the interface between General Practice and Mental Health NGOs in the Tamaki locality –
    - Develop programme to make available to all areas of Auckland by Q2
    - Initiate implementation in priority localities Q3-Q4
- Support National Framework for the Pharmacist Services in the Community by maintaining high quality medicines adherence and optimisation services, such as Long-Term Conditions (LTCs), Community Pharmacy Anticoagulation Services (CPAMS) and Medicine Use Reviews (MUR) – ongoing
- Support the focus areas identified in the Pharmacy Action Plan and making better use of pharmacist expertise by provision of MURs and clinical pharmacist services in residential aged care settings – ongoing
- Development and implementation of an education-based community pharmacy workforce development programme to further enhance the capability and capacity of the current Workforce. The programme will enable the Workforce to maximise their potential, and contribute to delivery of integrated high quality care to better meet the population health needs by June 2017
- Participate and contribute towards the national plan of commissioning of pharmacist services in the community via the new Community Pharmacy Services Agreement – ongoing
- Support the development and implementation of a sustainable national solution to pharmaceutical margins and efficient supply chain management via the new Community Pharmacy Services Agreement – ongoing
- Quarterly monitoring of LTC registrations, CPAMS, MUR volumes and workforce development programme completion rates – ongoing
- A new Community Pharmacy Services Agreement in place for the integration of pharmacist services in the community by June 2017
- Implement Stage One of the Cognitive Impairment standardised care model across both Auckland and Waitemata DHBs by 30 June 2017
- Implement finalised clinical protocol for ferinject in primary and community settings by June 2017.

Service reconfiguration

- Implement phase one of the Rural Alliance work-plan which will expand services to support increased access to diagnostics and interventions to rural communities by 30 June 2017
    - Complete stocktake of rural GP services Q1
    - Identify which services should be prioritised for investment in rural areas Q2
    - Develop business models and timeline for business case development by Q3
- Work with the PHOs to implement the new after-hours, over-night, and GP deputising services new agreement in place by 1 November 2016
- Develop an implementation plan to undertake service improvements arising from the Waiheke Island service review/engagement process by 31 March 2017.

Quality and safety of care

- Expand the Safety in Practice programme to 10 more participating general practices by June 2017.

Infrastructure and pathways

- Ongoing rollout of the Clinical Pathways Programme as per the agreed business case
- Complete POAC and Access to Diagnostics review and report on recommendations Q1
- Implement the recommendations of the POAC and Access to Diagnostics review by 31 March 2017
- Work with PHOs and regional POAC members to continue to increase the services across Auckland (target 7000 referrals). Expansion of services to support increased access to diagnostics and

Service Configuration, including Shifting Services and System Level Outcome Measures

interventions locally by 30 June 2017
- Continued implementation of Access to Diagnostics – ongoing

Shifting Services

Our priority for shifting services involves the continued development and implementation of:
- Increased commitment and expansion of POAC service to improve primary care response to acute demand – ongoing

System Level Outcome Measures
- Auckland DHB will provide a jointly developed and agreed (with PHOs and district alliances) Improvement Plan to the Ministry by 20 October 2016.

Living within our Means

We must be a financially sustainable and productive organisation while improving health outcomes and reducing inequalities for our community. Like all other DHBs, we operate in a financially constrained environment, where health expenditure is growing at a faster rate than health funding and where demand for health services is growing. We have lived within our means for the past four years, achieving over $200M of savings since 2012/13 (including the $26M planned for 2015/16) and planning a further $42M savings for 2016/17. The details of the savings programme have been included in the Annual Plan financial template and are summarised below.

Living within our Means

Health outcome: Achieving a financially sustainable health system

What are we aiming for in 2016/17? (Our measures)

Key measures
- Delivery of savings targets for the 2016/17 financial year – $42M
- Increase in other revenue streams through commercial contracts, research-funded studies, bequest programme, collaboration in research service with other DHBs, systems improvement – increases realised by June 2017.

Other measures
- Continue to work with the MoH in the 2016/17 year to ensure sustainable funding
- Continued development of region-wide service delivery models by June 2017
- Maintaining FTEs for non-clinical staff to within planned levels on an ongoing basis
- Detailed savings included in the Auckland DHB financial budgets (with monthly phasing) will be reported to the MoH on a monthly basis.

How will we achieve this?

The business transformation programme will continue into 2016/17 and beyond. The key areas of focus of this programme, to be delivered by June 2017, will include the following:
- Procurement and logistics savings arising from streamlining supply chain in theatres, better management of consignment stock, Surgical implants rationalisation, Pharmac pricing and rebates
- Bed Modelling /Length of Stay related savings from improved management of beds, better discharge planning/pathways and additional bed cost avoidance strategies
- Models of care reviews including skill mix review, Nurse Practitioner roles reviews, rostering reviews and management of cover for training programmes
- Standardisation of care and Diagnostic testing, including review of utilisation of imaging and laboratory services, benchmarking services and costs, redesigning service models for efficiency and improving production planning and increase productivity
- Regional Collaboration on services including joint metro approach to pathology services and delivery of additional electives
- Review effectiveness of current systems and processes

Living within our Means

- Implementing Support Service agency savings from procurement, inventory control and back-office efficiency initiatives (NZHPL, healthAlliance)
- Pharmac and healthAlliance are working jointly on the national procurement of medical devices for best health outcomes – ongoing
- Implementing revenue generation strategies through commercially funded research studies, service contracts, bequest programme, sharing research service, research cash-flow timing, systems control among other clinical and non-clinical revenue generation strategies
- Ongoing value for money service reviews
- Continuing to work with other DHBs to define the tertiary services they wish to have provided for their populations and the cost they wish to pay. Match service delivery to income. Work within the Northern region to determine the most clinically appropriate and cost effective pattern of service provision to meet patient need and access
- Continuing to work with MoH on DHB funding position – ongoing
- Ongoing work to ensure quality of services and delivery of benefits from the food, linen and laundry service changes
- Support the development and implementation of the National Oracle System, including commitment of resources (subject to Board decisions)
- Ongoing implementation of clinical support service efficiencies in Laboratory, Radiology, etc.

MODULE 3: Statement of Performance Expectations

The Statement of Performance Expectations is a requirement of the Crown Entities Act 2013 and identifies outputs, measures and performance targets for the 2016/17 year. Recent actual performance data are used as the baseline for targets.

Measures within this Statement of Performance Expectations represent those outputs/activities we deliver to meet our goals and objectives in Modules 1 and 2, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators. Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year-end by the DHB's auditors, AuditNZ.

Outcomes measurement framework

Auckland DHB's focus for 2016/17 is on making a positive impact on health outcomes; making sure people have a positive experience of our health services; and using resources efficiently. Our actions in 2016/17 need to contribute directly to the outcomes we want over the longer term. The outcomes and impacts in this section link to the national, regional and local strategic direction covered in Module 1 of this document.

Cost of outputs

Output Class Name	Prevention Services ($'000)	Early Detection and Management ($'000)	Intensive Assessment and Treatment ($'000)	Rehabilitation and Support ($'000)	Total ($'000)
Total Revenue	25,339	479,562	1,410,674	209,646	2,125,221
Expenditure					
Personnel	18,747	2,459	829,498	38,503	889,207
Outsourced Services	985	2	93,657	4,170	98,814
Clinical Supplies	238	142	249,161	5,443	254,983
Infrastructure & Non-Clinical Supplies	3,749	736	178,749	7,978	191,211
Payments to Providers	3,428	467,629	61,328	154,121	686,506
Total Expenditure	**27,147**	**470,968**	**1,412,392**	**210,214**	**2,120,721**
Net Surplus/(Deficit)	**(1,808)**	**8,594**	**(1,718)**	**(568)**	**4,500**

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was on target, was very close to target and where performance was less than expected.

The criteria used to allocate these grades are as follows:

Criteria		Rating	
On target or better		Achieved	
95–99.9%	0.1–5% away from target	Substantially achieved	
90–94.9%*	5.1–10% away from target*	Not achieved, but progress made	
<90%	>10% away from target**	Not achieved	

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

Key to output tables

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

Output class 1: Prevention Services

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

More than one quarter of deaths are preventable (26%), and for CVD, the leading cause of death, up to 70% can be avoided (HNA, 2015). Effective prevention services can therefore have a significant impact on health outcomes.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Health promotion				
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Q	96%	95%	Q2 2015/16
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking in the last 15 months	Q	86%	90%	Q2 2015/16
Percentage of pregnant women who identify as smokers upon registration with a DHB-midwife or LMC are offered brief advice and support to quit smoking	Q	100%	90%	Q3 2015/16
Raising Healthy Children HT: Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	New indicator	95%	
Number of adults referred to Green Prescriptions	V	5,003	6,152	2014/15
Enforcement of the Smokefree Environments Act 1990[1]				
Number of retailer compliance checks conducted	V	284	300	2014/15
Health protection				
Tuberculosis (TB)[1]				
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	99.9%	≥85%	2014/15
Population-based screening				
Breast Screening				
Coverage rates among eligible groups (age 45–69 years)	C	65%	70%	Sep 2015
Newborn Hearing Screening				
Number/proportion of babies offered screened within 1 month	V	97.15%	90%	CY 2015
Referral rate to audiology ≤4%	Q	2.1%	≤4%	CY 2015
Percentage of appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme	T	100%	≥95%	CY 2015
Children				
Percentage of B4 School Checks completed	C	96%	90%	Q2 2015/16

Note: 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

[1] These services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support these measures is for all three metro Auckland DHBs

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. 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. Early detection and management services also enable patients to maintain their functional independence and prevent relapse of illness.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Primary health care				
Primary care enrolment rates	C	91%	95%	Sep 2015
Number of referrals to POAC (Primary Options for Acute Care)	V	4539	7000	April 2015 – Mar 2016
Increased immunisation HT: percent of eight months olds will have their primary course of immunisation on time	C	94%	95%	Q3 2015/16
HPV vaccination coverage rate (for dose 3)	C	82%	70%	Q2 2015/16
Seasonal influenza immunisation rates in people aged 65+ years	C	65%	75%	Q1 2015/16
Cervical screening coverage rate	C	80%	80%	Q2 2015/16
Percentage of people with diabetes whose HbA1c at their annual review was ≤64 mmol/mol	Q	60%	61%	Q2 2015/16
Percentage of patients with prior CVD who are prescribed triple therapy	Q	53.5%	70%	Oct 2014-Sep 2015
Proportion of the eligible population who have had their cardiovascular disease risk assessed in the last five years	C	92%	90%	Q2 2015/16
Community-referred testing and diagnostics				
Number radiological procedures referred by GPs to hospital	V	46,794	Ω	CY 2015
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 96% MRI 52%	CT 95% MRI 85%	Q2 2015/16
Oral health				
Mean decayed, missing, filled teeth (DMFT) at year 8 ratio	Q	0.84	0.85	CY2015
Children caries free at five years of age	Q	58%	70%	CY2015

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers. 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 and include:

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

Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Acute services				
Number of Emergency Department (ED) attendances	V	102,089	Ω	CY 2015
Total acute WIES provided	V	94,280	94,755	CY 2015
Shorter stays in Emergency Departments HT: percentage of ED patients discharged admitted or transferred within six hours of arrival	Q	95%	95%	Q2 2015/16
Faster Cancer Treatment HT: percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	69.2%	85%	Q2 2015/16
Percentage of potentially eligible stroke patients thrombolysed	Q	10.8%	10%	Q1 2015/16
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Q	86%	80%	Q2 2015/16
Percentage of ACS inpatients receiving coronary angiography within 3 days	T	89.3%	70%	Q2 2015/16
Maternity				
Number of births in Auckland DHB hospitals	V	7,076	Ω	CY 2015
Percentage of patients with third/fourth degree tears for all primiparous vaginal births	Q	5.3%	↓	2015
Proportion of women booking before end of 1st trimester	Q	46%	80%	CY2015
Elective (inpatient/outpatient)				
Improved access to elective surgery HT: number of elective surgical discharges	V	15,899	17,230	2014/15
Surgical intervention rate (per 10,000 population) - Major Joints - Cataracts - Cardiac surgery - Angioplasty - Angiogram	C	 17.7 36.6 5.2 11.2 30.8	 21 27 6.5 12.5 34.7	2015/16
Percentage of people receiving urgent diagnostic colonoscopy in 14 days Percentage of people receiving non-urgent diagnostic colonoscopy in 42 days	T	85% 70%	98% 56%	Mar 2016
Percentage of patients waiting longer than four months for their first specialist assessment (FSA)	T	0.2%	0%	Jan 2016
Percentage of patients given a commitment to treatment but not treated within four months	T	1.4%	0	Jan 2016

Quality and patient safety				
Percentage of opportunities for hand hygiene taken	Q	80%	81%	Q2 2015/16
Percentage of older patients assessed for risk of falling	Q	92%	90%	Q2 2015/16
Percentage of operations[2] where antibiotic given in hour before incision	Q	96%	100%	Q2 2015/16
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.18	↓	CY 2015
Percentage of inpatient respondents who rate their care and treatment as very good or excellent	Q	84.3%	↑	Q2 2015/16
Mental health				
Percentage of population who access mental health services: Age 0–19 years Age 20–64 years Age 65+ years (total)	C	 2.88% 3.75% 3.04%	 3.0% 3.7% 3.1%	Oct 2014 to Sep 2015
Percentage of 0-19 year old clients seen within 3 weeks: - Mental Health - Addictions Percentage of 0-19 year old clients seen within 8 weeks: - Mental Health - Addictions	T	 77.3% 93% 96% 96%	 80% 95%	Oct 2014 to Sep 2015

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support services and residential care services.

Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs on the health system.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Home-based support				
Proportion of people aged 65+ years receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan (InterRAI)	Q	96%	95%	Q1 2015/16
% of urgent interRAI referrals assessed within 5 working days % of non-urgent interRAI referrals assessed within 15 working days	T	100% 76%	90% 90%	Q3 2015/16
Palliative care				
Number of contacts	V	10,677	Ω	2015/16
Proportion of hospice patient deaths that occur at home	Q	24%	↑	2014/15
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	1%	↓	2014/15
Residential care				
Proportion of aged care providers with 4 year audit certification	Q	23%	↑	2014/15

[2] Hip and knee arthroplasties

Module 4: Financial Performance

Financial management overview

Our goal is to provide the best health service, with the resources we have for our local, regional and national population today and into the future.

Significant steps have been taken to reduce costs at Auckland DHB over the past four years. A comprehensive savings programme has delivered savings in excess of $200M since 2012/13.

The forecast year-end surplus for 2015/16 is a surplus of $2.4M. The surplus is due to good financial management and the DHB teams working together to ensure we live within our means.

To maintain a high quality health service that is financially sustainable into the future, we recognise that a deliberate strategy is required. This includes:

- Prioritising our work programmes to get the best health service for the people locally, regionally and nationally
- Continuing to embed a culture of financial accountability and discipline underpinned by a Business Transformation and Performance Improvement Programme to continuously identify and implement improvement initiatives
- Careful planning and implementation of affordable capital developments
- Delivering quality health services more efficiently and more cost effectively in partnership with our Waitemata DHB colleagues and nationally through existing shared service agencies such as healthAlliance.

Based on year-to-date (May 2016) financial performance and expectations for the rest of this financial year:

- We are forecasting a year end surplus of $2.4M for 2015/16. Part of the surplus reflects additional funding expected in June that will not have been applied to services yet. To achieve the planned result for the year and maintain financial sustainability, we have continued to effectively manage Inter District Flow (IDF) revenue and expenditure, contain cost pressures across our services and successfully progress our business transformation and performance improvement initiatives. The savings target for 2015/16 of $26M is expected to be fully achieved, including unplanned savings that offset any that are no longer achievable
- We are providing for known IDF-related risks and continuing to ensure we meet planned IDF volume levels and minimise this risk
- There will be a full land and buildings asset revaluation is to be completed as at 30 June 2016. The value of land for Auckland DHB has been increasing for the past three years, with flow on impact on Equity and Capital Charge.

Our focus and commitment to maintaining long-term financial sustainability requires us to be more purposeful and deliberate in planning the best use of our staff and the capital resources available to us well into the future. Living within our means is core to sustaining our services and we are planning to achieve surplus results in each of the four planning years 2016/17 to 2019/20), which can be applied to capital expenditure.

We will continue to look after our assets through appropriate upgrades, refurbishments, replacements and maintenance using cash flow from depreciation. We will use our limited funds carefully for new facility, clinical equipment and technology investments to support the growth and improvements in health services. Given the limited capital envelope, we will continue to work and collaborate with our regional partners to ensure that we are making the right capital investments, in the right places and at the right time.

Significant steps have been taken to reduce costs at Auckland DHB over the past four years, underpinned by a comprehensive savings programme. This delivered savings in excess of $200M between 2012/13 and 2015/16. For 2016/17, we are planning savings of $42M which is a significant undertaking given savings achieved to date.

This plan was developed on the understanding that Auckland DHB will, supported by the Ministry, resolve IDF expenditure and funding gaps. Some of the strategies to bridge the expenditure gap include looking at cost drivers, efficiency and productivity whilst the funding gap will require the DHB agreeing with other DHBs a different funding model for IDFs. The agreed process for wash-up of IDF funding with affected DHBs will need to be finalised before the end of the 2016/17 financial year.

The creation of more manageable directorates, led by clinical leaders as the single points of accountability is now complete. This is an enabler for sustainable system change required to meet health needs within our budget.

Clinical Services Planning has started, this will help us better understand the current capacity for services we provide, the future needs and the long-term demand profile for services. In turn this will enable us to plan capital investment and our future workforce for models of care that support long term clinically and financially sustainable services.

Key Assumptions for Financial Projections

Revenue Growth

Most of Auckland DHB's revenue is from the Ministry of Health, mainly population based funding for the Auckland DHB population, IDF revenue (for services delivered for other DHBs' populations) and funding for the national services we provide.

The funding growth advised in the December Funding Envelope update for the Auckland DHB for 2016/17 was $39.6M (3.46%) more than 2015/16. Additional funding advised in February 2016 including net changes in IDF revenue has also been included in the financial plans.

Included in the net funding changes year-on-year are the following:

- $73M reduction in IDFs reflecting an agreed change in treatment of funding for laboratory and PHO services (with associated reduction in expenditure) that was agreed with Waitemata DHB. Auckland acts as an agent for Waitemata DHB in relation to payments for these services; and
- $26M reduction resulting from the transfer of national paediatric services funding from IDFs into top slices.

As per the guidance from the Ministry of Health, we have assumed for outer years that Funding Envelope Revenue from the Ministry of Health (including PBFF and IDFs) will increase at the same nominal value as that signalled for 2016/17. For IDFs, no further service changes to the IDF envelope advised have been assumed.

Other revenue is based on contractual arrangements in place and reasonable estimates on a line-by-line basis.

In our March and May Annual Plan submissions, we included an assumption of additional Ministry of Health revenue of $20M to facilitate a breakeven result. The Ministry of Health have since advised additional funding for the DHB of $10.3M, of which $4.7M has associated expenditure ($1.0M additional electives, $3.7M pharmaceutical investment and $0.03M home and community support services). Of the balance with no tagged expenditure, the DHB has been asked to generate a surplus for each of the planning years (2016/17 $4.5M) – this surplus to be applied to capex. It is assumed in this plan that the funding received to achieve this result will continue to be provided to the DHB by the Ministry.

A number of issues are being raised with the sector with respect to tertiary and national service volumes and pricing. There is also a Board-led, independent review underway. The purpose of the review is to re-examine the budget process, verify the budget, explore further efficiencies and cost reductions, and provide independent advice regarding potential solutions to the current financial challenge. The Board and management are fully engaging with the Ministry to find solutions.

The balanced budget planned for 2016/17 and out-years is premised on the additional funding being provided and delivery of the $42M savings programme.

Expenditure Growth

The underlying cost growth is driven by demographic growth pressure on services provided for the local and regional population, cost growth to meet national services demand growth, cost growth for employment contracts (including automatic step increases), cost of capital for facility developments and general inflationary pressure on clinical and non-clinical supplies and services. Key expenditure assumptions include:

- Increase of more than 3% for our own Auckland population, the IDF population and national services
- An estimated increase of $22M in personnel costs (net of efficiencies) over 2015/16 of all settled employment agreements, automatic step increases, SMO job sizing allowances, increase in FTEs, risk provisions for expired employment contracts and of employment agreements. FTE numbers for 2016/17 are planned to grow by 244 from 2015/16 forecast level, with increases across all employee categories
- Clinical supplies growth is based on known inflation factor in contracts, estimation of price change on supplies and adjustments for known specific information within and growth in services provided by the DHB. healthAlliance Procurement and Supply chain teams and other national entities continue to negotiate contract prices to realise more savings in this area
- Infrastructure cost growth (not including interest, depreciation and capital charge) in this category are based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. While these have resulted in increases we have been able to contain these costs by reductions in other costs in the same category
- The Business Transformation and Performance Improvement Programme is a key strategy being applied to manage cost pressures via savings. For 2016/17, savings are planned at $42M
- Funder payments reflect historical growth patterns and with expected growth factored in
- Impact of interest income from the shared banking arrangements in place and interest expense for the Crown debt is included
- Outer Years Expenditure growth is planned in line with the advised future funding growth path. Based on the last four years' financial planning and performance, it is anticipated that savings will be required to live within the funding advised
- Additional expenditure has been included in the plan following advice from the Ministry of Health on additional funding which has corresponding expenditure increases.

Financial Risks

Performance improvement initiatives have resulted in savings of more than $200M since 2012/13.

We consider most of these savings to be mainly the 'low hanging fruit' and process changes implemented within the DHB, regionally and nationally (including back-office functions and procurement initiatives).

To continue to achieve savings may require more radical changes to how we deliver services and potentially more investment, particularly in technology.

Achieving $42M incremental savings from performance improvement initiatives is a challenge considering the progressive savings achieved to date in excess of $200M since the start of the initiative in 2012/13. Initiatives considered to be most difficult to achieve are those that relate to skill mix reviews and those where we rely on external stakeholders to deliver. Risk assessment of savings will be an ongoing programme to ensure that where planned savings are no longer achievable, offsetting ones will have to be identified and implemented in order to achieve the planned breakeven position. A management accountability structure is in place for the savings programme. This includes monitoring and surveillance processes that assure deviation from the planned programme will be reported and acted upon.

There are a number of developments underway to improve planning information and processes for the DHB going forward. These include:

- The Clinical Services Planning to better understand service capacities, future demand growth and reviewing models of care and their sustainability over the long term

- Feasibility studies underway for investment in IT will provide better clarity of areas of potential change in models of care
- Developing the Auckland DHB Long Term Investment Plan to inform the capital required to maintain and increase capacity so we can continue providing services to our local and national population
- Asset verification and condition assessments underway will inform future investment requirements
- Investor Confidence Rating is underway, this will help inform the DHB's maturity and improvements required to deliver investment projects and realise planned benefits, manage change and the overall system. A roadmap for the improvement programme will be developed following the completion of the Investor Confidence Rating assessment.

Forecast Financial Statements

The Board of Directors of the Auckland District Health Board (Auckland DHB) are responsible for the issue of the forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The forecast financial statements are authorised by the Board of Directors for issue on 26 May 2016. Subsequent to authorisation and submission of the Annual Plan in May 2016, additional funding has been advised and funding assumptions revised to ensure the Ministry request for the additional funding, expenditure and required surpluses is reflected in the financial plans and Annual Plan/Statement of Intent.

The forecast financial statements have been prepared to comply with the requirements of Section 149G of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose. It is not intended for the forecast financial statements to be updated within the next 12 months.

In line with the requirements of Section 149G of the Crown Entities Act 2004, we provide both the forecast financial statements of Auckland DHB and its subsidiaries (together referred to as "Group") and Auckland DHB's interest in associates and jointly controlled entities.

The Auckland DHB group consists of the parent, Auckland DHB and Auckland District Health Board Charitable Trust (controlled by Auckland DHB). Joint ventures are with healthAlliance N.Z. Limited and NZ Health Innovation Hub Management Limited. The associate companies are Northern Regional Alliance Limited, formerly called Northern DHB Support Agency Limited (NDSA).

The tables below provide a summary of the forecast consolidated financial statements for the audited result for 2014/15, year-end forecast for 2015/16 and plans for years 2016/17 to 2019/20. The forecast financial statements have been prepared on the basis of the key assumptions for financial forecasts and the significant accounting policies summarised in Significant Accounting Policies outlined below. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Statement of Comprehensive Revenue and Expenses – Group

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,269,699	1,301,771	1,391,733	1,435,764	1,479,303	1,522,353
Non-Government & Crown Agency Sourced	86,904	82,397	84,435	77,915	78,813	79,745
IDFs & Inter-DHB Sourced	702,167	665,270	649,053	670,350	691,647	712,945
TOTAL FUNDING	**2,058,770**	**2,049,438**	**2,125,221**	**2,184,029**	**2,249,764**	**2,315,044**
EXPENDITURE						
Personnel Costs	830,230	867,226	889,207	911,427	938,739	966,872
Outsourced Costs	103,651	105,839	98,814	100,851	103,010	105,216
Clinical Supplies Costs	238,447	244,783	254,983	259,584	266,423	273,803
Infrastructure & Non-Clinical Supplies Costs	185,969	192,340	191,211	198,245	205,255	210,901
Payments to Providers	590,132	525,125	571,707	590,791	609,874	628,956
IDF Outfows	110,189	111,776	114,800	118,632	122,463	126,295
TOTAL EXPENDITURE	**2,058,617**	**2,047,089**	**2,120,721**	**2,179,529**	**2,245,764**	**2,312,044**
Share of associate and joint venture surplus/(deficit)	**202**	**42**	-	-	-	-
NET SURPLUS/(DEFICIT)	**355**	**2,392**	**4,500**	**4,500**	**4,000**	**3,000**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	31,828	-	-	-	-	-
Cash flow hedges	(4,293)	552	552	552	552	552
TOTAL COMPREHENSIVE INCOME	**27,890**	**2,944**	**5,052**	**5,052**	**4,552**	**3,552**

The surplus of $4.5M planned for 2016/17 is achieved primarily from additional funding provided by the Ministry and assuming $42M savings will be achieved in the year. Surpluses are also planned for each of the planning years and assume that the additional revenue advised in June 2016 continues to be provided by the Ministry.

The 2015/16 forecast surplus of $2.4M primarily relates to funding expected to be received late in the year and that will not be applied to service provision in 2015/16. The DHB is committed to sustainable financial performance throughout the planning period and onwards. This will require ongoing ability to contain costs in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

As revenue continues to grow at a slower rate, the ability to achieve financial breakeven is more and more dependent on the success of savings and productivity initiatives undertaken. The need to continue to increase elective volumes in line with the rest of New Zealand means that productivity improvements, process improvements, efficiencies and savings need to be vigorously pursued by Auckland DHB.

Statement of Comprehensive Revenue and Expenses – Parent

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,269,699	1,301,771	1,391,733	1,435,764	1,479,303	1,522,353
Non-Government & Crown Agency Sourced	85,969	81,937	84,023	77,333	78,052	78,796
IDFs & Inter-DHB Sourced	702,167	665,270	649,053	670,350	691,647	712,945
TOTAL FUNDING	**2,057,835**	**2,048,978**	**2,124,809**	**2,183,447**	**2,249,003**	**2,314,095**
EXPENDITURE						
Personnel Costs	830,230	867,226	889,207	911,427	938,739	966,872
Outsourced Costs	103,651	105,839	98,814	100,851	103,010	105,216
Clinical Supplies Costs	238,447	244,783	254,983	259,584	266,423	273,803
Infrastructure & Non-Clinical Supplies Costs	187,103	193,351	192,641	199,588	206,524	212,083
Payments to Providers	590,132	525,125	571,707	590,791	609,874	628,956
IDF Outflows	110,189	111,776	114,800	118,632	122,463	126,295
TOTAL EXPENDITURE	**2,059,751**	**2,048,100**	**2,122,151**	**2,180,872**	**2,247,033**	**2,313,226**
Joint venture	-	42	-	-	-	-
NET SURPLUS/(DEFICIT)	**(1,916)**	**921**	**2,658**	**2,575**	**1,970**	**869**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	31,828	-	-	-	-	-
Cash flow hedges	(4,293)	552	552	552	552	552
TOTAL COMPREHENSIVE INCOME	**25,619**	**1,473**	**3,210**	**3,127**	**2,522**	**1,421**

Interest, Depreciation and Capital Charge

We note that included in the infrastructure and non-clinical supplies costs are capital-related costs in the form of Interest, Depreciation and Capital Charge (IDCC), which represent at least 50% of this cost category. Interest costs are driven by the applicable interest rates on the Crown debt portfolio of $304.5M. Depreciation reflects the size and value of our asset base and rates of annual usage applied to the asset classes, with the increase in depreciation reflecting continued investment in facilities and equipment over time and impact of asset revaluations. Capital charge reflects the Crown's return on investment in the DHB and is impacted by upward movements in asset valuations. These costs are summarised in the table below.

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
INTEREST, DEPRECIATION & CAPITAL CHARGE						
Interest	15,949	12,952	12,497	12,806	13,144	13,356
Depreciation	41,373	45,495	47,474	52,705	55,830	58,928
Capital Charge	40,478	42,905	43,140	43,322	43,821	44,246
TOTAL INTEREST, DEPRECIATION & CAPITAL CHARGE	**97,800**	**101,352**	**103,110**	**108,833**	**112,795**	**116,530**
% of Infrastructure & Non Clinical Supply Costs	**53%**	**53%**	**54%**	**55%**	**55%**	**55%**

To maintain overall sustainability, we need to continue investing in assets required to support the growing demand for our services. To maintain financial sustainability, this investment needs to be affordable to the DHB, meaning that all associated financing costs have to be met from funding available.

Statement of Cashflows – Group

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
MoH and other Government/Crown	1,977,208	1,960,394	2,040,786	2,106,115	2,170,950	2,235,298
Other Income	73,507	68,690	76,606	71,130	72,413	73,325
	2,050,715	2,029,084	2,117,392	2,177,245	2,243,364	2,308,624
Cash was applied to						
Payments for Personnel	(825,171)	(870,162)	(885,939)	(908,087)	(935,329)	(963,389)
Payments for Supplies	(413,794)	(434,039)	(439,712)	(449,844)	(461,881)	(473,473)
Capital Charge Paid	(40,478)	(42,905)	(43,140)	(43,322)	(43,821)	(44,246)
Net GST Paid	2,536	(2,134)	-	-	-	-
Payments to Providers and other DHBs	(700,320)	(636,901)	(686,506)	(709,423)	(732,337)	(755,251)
	(1,977,228)	(1,986,140)	(2,055,296)	(2,110,676)	(2,173,368)	(2,236,359)
NET CASHFLOW FROM OPERATING ACTIVITIES	73,486	58,107	42,944	62,095	66,569	69,995
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	7,902	5,455	7,830	6,785	6,400	6,420
Proceeds from Sale of Fixed Assets	28	189	-	-	-	-
Decrease/(Increase) in Investments	(1,917)	(30,288)	15,000	3,951	-	-
	6,013	(24,644)	22,830	10,736	6,400	6,420
Cash was applied to						
Capital Expenditure	(65,395)	(60,235)	(70,867)	(62,289)	(58,249)	(62,071)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(59,382)**	**(99,203)**	**(84,879)**	**(48,037)**	**(51,553)**	**(51,849)**
FINANCING ACTIVITIES						
Proceeds from Capital Raised/(Repaid) from the Crown	(80,000)	-	-	-	-	-
Proceeds from Loans Raised	80,000	996	4,900	4,244	4,425	2,906
Cash flow hedge	(4,405)	-	-	(6)	3	(1)
Interest Paid	(16,051)	(13,145)	(11,972)	(12,238)	(12,592)	(12,804)
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**(20,456)**	**(12,149)**	**(7,072)**	**(8,001)**	**(8,164)**	**(9,899)**
NET CASH INFLOW/(OUTFLOW)	**(6,352)**	**(54,084)**	**6,989**	**7,015**	**9,982**	**6,715**
Cash & cash equivalents at the start of the year	**90,210**	**83,858**	**29,774**	**36,760**	**43,775**	**53,757**
Cash & cash equivalents at the end of the year	**83,858**	**29,774**	**36,760**	**43,775**	**53,757**	**60,472**

Cash flow forecasts reflect the planned operating surplus result. Surpluses give rise to cash surpluses, essentially from the depreciation stream and also from operating surpluses, which can be used to fund the capital projects approved by the Auckland DHB Board. The capital plan includes significant investments in replacing, maintaining and upgrading our current asset base, investing in technology assets and also in assets required to meet growth, quality improvements and compliance. Our borrowing facilities with the Ministry of Health increased to $304.5M from September 2015, following the refinancing of private sector bonds put in place in 2000 and that matured in September. We no longer have any private sector debt facilities, with all debt now sitting with the Crown.

Statement of Cashflows – Parent

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
MoH and other Government/Crown	1,977,208	1,960,394	2,040,786	2,106,115	2,170,950	2,235,298
Other Income	71,661	68,379	75,030	69,193	70,379	71,190
	2,048,869	2,028,773	2,115,816	2,175,308	2,241,330	2,306,489
Cash was applied to						
Payments for Personnel	(825,171)	(870,162)	(885,939)	(908,087)	(935,329)	(963,389)
Payments for Supplies	(410,462)	(432,971)	(438,142)	(447,816)	(460,050)	(471,555)
Capital Charge Paid	(40,478)	(42,905)	(43,140)	(43,322)	(43,821)	(44,246)
Net GST Paid	2,319	(2,134)	-	-	-	-
Payments to Providers	(700,320)	(636,901)	(686,506)	(709,423)	(732,337)	(755,251)
	(1,974,113)	1,985,072)	(2,053,726)	(2,108,648)	(2,171,537)	(2,234,441)
NET CASHFLOW FROM OPERATING ACTIVITIES	74,755	43,701	62,089	66,660	69,792	72,048
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	7,009	4,534	6,394	5,278	4,817	4,758
Proceeds from Sale of Fixed Assets	28	189	-	-	-	-
Decrease/(Increase) in Investments	(2,293)	(30,124)	16,442	5,367	1,786	1,879
	4,744	(25,401)	22,836	10,645	6,603	6,637
Cash was applied to						
Capital Expenditure	(65,395)	(60,235)	(70,867)	(62,289)	(58,249)	(62,071)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(60,651)**	**(85,636)**	**(48,031)**	**(51,644)**	**(51,646)**	**(55,434)**
FINANCING ACTIVITIES						
Proceeds from Capital Raised/(Repaid) from the Crown	(80,000)	-	-	-	-	-
Proceeds from Loans Raised	80,000	-	4,900	4,244	4,425	2,906
Cash flow hedge	(4,405)	-	-	(6)	3	(1)
Interest Paid	(16,051)	(13,145)	(11,972)	(12,238)	(12,592)	(12,804)
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**(20,456)**	**(13,145)**	**(7,072)**	**(8,001)**	**(8,164)**	**(9,899)**
NET CASH INFLOW/(OUTFLOW)	**(6,352)**	**(55,080)**	**6,986**	**7,015**	**9,982**	**6,715**
Cash & cash equivalents at the start of the year	**90,210**	**83,858**	**28,778**	**35,764**	**42,779**	**52,761**
Cash & cash equivalents at the end of the year	**83,858**	**28,778**	**35,764**	**42,779**	**52,761**	**59,476**

Statement of Financial Position – Group

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	83,858	29,774	36,760	43,774	53,757	60,473
Trust/special funds/Other Investments	11,852	29,035	19,035	15,020	16,067	17,179
Debtors & other receivables	56,359	64,202	62,049	62,052	62,050	62,047
Prepayments	1,035	1,679	1,679	1,679	1,679	1,679
Inventories	13,154	14,239	14,239	14,239	14,239	14,239
	166,258	138,929	133,761	136,764	147,792	155,616
Non-current assets						
Trust/special funds/Other Investments	17,299	19,495	14,494	14,923	15,662	16,429
Property, Plant and Equipment	952,323	969,063	991,766	1,003,567	1,009,374	1,016,701
Intangible Assets	13,330	13,182	13,873	12,709	9,321	5,137
Investment in joint ventures & associates	42,632	53,606	53,606	53,606	53,606	53,606
	1,025,584	1,055,346	1,073,739	1,084,805	1,087,963	1,091,873
TOTAL ASSETS	**1,191,842**	**1,194,274**	**1,207,500**	**1,221,569**	**1,235,755**	**1,247,489**
LIABILITIES						
Current liabilities						
Trade and other payables	148,422	151,154	151,497	153,276	155,431	157,586
Employee benefits	159,463	148,402	151,333	154,326	157,381	160,502
Interest-bearing loans & borrowings	52,454	2,140	52,752	7,765	39,984	27,027
	360,340	301,696	355,582	315,367	352,796	345,115
Non-current liabilities						
Employee Benefits	30,085	37,653	37,653	37,653	37,653	37,653
Interest-bearing loans & borrowings	254,500	305,065	259,353	308,584	280,790	296,653
	284,585	342,718	297,006	346,237	318,443	334,306
TOTAL LIABILITIES	**644,925**	**644,414**	**652,587**	**661,604**	**671,239**	**679,421**
EQUITY						
Public Equity	576,798	576,798	576,798	576,798	576,798	576,798
Accumulated deficit	(488,745)	(487,824)	(485,165)	(482,598)	(480,629)	(479,760)
Other reserves	438,457	438,457	438,457	438,457	438,457	438,457
Cash flow hedge reserve	(4,293)	(3,741)	(3,189)	(2,637)	(2,085)	(1,533)
Trust/special funds	24,699	26,170	28,012	29,945	31,975	34,106
TOTAL EQUITY	**546,917**	**549,860**	**554,913**	**559,965**	**564,516**	**568,068**
NET ASSETS	**546,917**	**549,860**	**554,913**	**559,965**	**564,516**	**568,068**

A strong asset base is indicated, with total assets planned to maintain a value greater than $1.2B throughout the planning period. Full land and building asset revaluations will be completed as at 30 June 2016. The impact of this has not been included in the Annual Plan financial plan. Any increase in capital charge arising from impact of asset revaluations of Crown Equity is assumed to be fully funded by the Ministry of Health as per current policy, hence will have a neutral impact on the DHB bottom-line.

The Cashflow Hedge reserve relates to the hedge accounting treatment of the Bond FRA settled in April 2015. This is being amortised over eight years to 2023.

Statement of Financial Position – Parent

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	83,858	29,774	36,760	43,774	53,757	60,473
Trust/special funds/Other Investments	1,208	12,548	1,835	(3,165)	(3,165)	(3,165)
Debtors & other receivables	59,129	64,363	61,810	61,676	61,530	61,375
Prepayments	1,035	1,679	1,679	1,679	1,679	1,679
Inventories	13,154	14,239	14,239	14,239	14,239	14,239
	158,384	122,603	116,322	118,203	128,040	134,600
Non-current assets						
Trust/special funds/Other Investments	(0)	7,875	2,145	2,144	2,144	2,144
Property, Plant and Equipment	951,423	968,163	990,866	1,002,666	1,008,473	1,015,800
Intangible Assets	13,330	13,182	13,873	12,709	9,321	5,137
Investment in joint ventures & associates	42,172	53,146	53,146	53,146	53,146	53,146
	1,006,925	1,042,366	1,060,030	1,070,665	1,073,084	1,076,227
TOTAL ASSETS	**1,165,309**	**1,164,968**	**1,176,352**	**1,188,868**	**1,201,124**	**1,210,827**
LIABILITIES						
Current liabilities						
Trade and other payables	147,303	148,733	149,076	151,227	153,482	155,737
Employee benefits	159,463	148,402	151,333	154,326	157,381	160,502
Interest-bearing loans & borrowings	52,454	2,140	52,752	7,765	39,984	27,027
	359,221	299,275	353,161	313,318	350,847	343,266
Non-current liabilities						
Employee Benefits	30,085	37,653	37,653	37,653	37,653	37,653
Interest-bearing loans & borrowings	254,500	305,065	259,353	308,584	280,790	296,653
Patient & restricted trust funds	-	-	-	-	-	-
	284,585	342,718	297,006	346,237	318,443	334,306
TOTAL LIABILITIES	**643,806**	**641,993**	**650,166**	**659,555**	**669,290**	**677,572**
EQUITY						
Public Equity	576,798	576,798	576,798	576,798	576,798	576,798
Accumulated deficit	(489,460)	(488,539)	(485,880)	(483,305)	(481,336)	(480,467)
Other reserves	438,457	438,457	438,457	438,457	438,457	438,457
Cash flow hedge reserve	(4,293)	(3,741)	(3,189)	(2,637)	(2,085)	(1,533)
Trust/special funds	-	-	-	-	-	-
TOTAL EQUITY	**521,503**	**522,975**	**526,186**	**529,313**	**531,834**	**533,255**
NET ASSETS	**521,503**	**522,975**	**526,186**	**529,313**	**531,834**	**533,255**

Disposal of Land

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

Statement of Changes in Net Assets/Equity – Group

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
BALANCE AT 1 JULY	**519,027**	**546,917**	**549,860**	**554,913**	**559,965**	**564,516**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	355	2,392	4,500	4,500	4,000	3,000
Gains/(Losses) on Property Revaluations	31,828	-	-	-	-	-
Cashflow Hedge Reserve	(4,293)	552	552	552	552	552
TOTAL COMPREHENSIVE INCOME	**546,917**	**549,860**	**554,913**	**559,965**	**564,516**	**568,068**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	-	-	-	-	-	-
BALANCE AT 30 JUNE	**546,917**	**549,860**	**554,913**	**559,965**	**564,516**	**568,068**

The shareholder's equity position improved in 2014/15 due to the increase in the value of land at 30 June 2015 and an improvement of $552K a year results from the amortisation of the Cashflow hedge reserve. A further increase is anticipated from asset revaluations underway.

Statement of Changes in Net Assets/Equity – Parent

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
BALANCE AT 1 JULY	**495,884**	**521,503**	**522,979**	**526,184**	**529,309**	**531,827**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	(1,916)	921	2,658	2,575	1,960	869
Gains/(Losses) on Property Revaluations	31,828	-	-	-	-	-
Cashflow Hedge Reserve	(4,293)	552	552	552	552	552
TOTAL COMPREHENSIVE INCOME	**25,619**	**1,473**	**3,210**	**3,127**	**2,522**	**1,421**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	-	-	-	-	-	-
BALANCE AT 30 JUNE	**521,503**	**522,975**	**526,186**	**529,313**	**531,834**	**533,255**

Additional Information

Financial performance for each of the DHB arms is summarised in the tables on the following pages.

Funder Arm Financial Performance

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
REVENUE						
Government & Crown Agency Sourced	1,177,009	1,208,154	1,294,458	1,337,517	1,380,073	1,422,131
Non-Government & Crown Agency Sourced	245	235	-	-	-	-
IDFs & Inter-DHB Sourced	686,494	648,270	633,262	654,401	675,538	696,675
TOTAL REVENUE	**1,863,747**	**1,856,659**	**1,927,720**	**1,991,918**	**2,055,611**	**2,118,806**
EXPENDITURE						
Payment to Provider	1,145,864	1,188,836	1,224,981	1,265,870	1,306,758	1,347,646
Payment to Governance	10,975	11,331	11,733	12,125	12,516	12,908
	1,156,840	**1,200,167**	**1,236,714**	**1,277,995**	**1,319,274**	**1,360,555**
NGO Expenditure						
Personal Health	417,308	342,677	382,943	395,726	408,508	421,290
Mental Health	37,976	37,657	37,682	38,940	40,198	41,456
DSS	132,176	141,275	146,248	151,129	156,011	160,892
Public Health	1,272	2,289	3,428	3,542	3,656	3,771
Māori Health	1,400	1,227	1,406	1,454	1,501	1,548
	590,132	**525,125**	**571,707**	**590,791**	**609,873**	**628,956**
IDF Outflows	110,189	111,776	114,800	118,632	122,463	126,295
	700,320	**636,901**	**686,506**	**709,423**	**732,337**	**755,251**
TOTAL EXPENDITURE	**1,857,160**	**1,837,068**	**1,923,220**	**1,987,418**	**2,051,611**	**2,115,806**
SURPLUS/(DEFICIT)	**6,587**	**19,591**	**4,500**	**4,500**	**4,000**	**3,000**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME	**6,587**	**19,591**	**4,500**	**4,500**	**4,000**	**3,000**

The provider has been allocated its Ministry of Health base funding using national prices. The DHB's Production Plan, provided as part of this planning package, summarises the service volumes planned to be delivered by the provider and including increases over levels delivered in 2015/16.

The joint Funder collaboration arrangements between Auckland and Waitemata DHBs remain in place, with Funding Administration staff employed by Waitemata DHB on behalf of the two DHBs. Funder arm financial plans and performance for Auckland DHB continue to be reported through the Auckland DHB financial accounts and statement of service performance.

Additional funding resulting in the overall DHB surplus is accounted for in the DHB funder arm. The planned Funder result assumes funding for this is sustained in future years.

Provider Arm Financial Performance

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
INCOME						
MoH Base via Funder	1,161,160	1,204,973	1,240,772	1,281,820	1,322,867	1,363,917
MoH Direct	54,455	59,610	59,538	60,133	60,734	61,342
Other	124,863	116,208	122,172	116,029	117,309	118,626
TOTAL INCOME	**1,340,477**	**1,380,791**	**1,422,482**	**1,457,982**	**1,500,910**	**1,543,884**
EXPENDITURE						
Personnel	825,626	863,948	885,898	908,045	935,286	963,345
Outsourced Services	93,592	97,713	89,066	90,899	92,849	94,841
Clinical Supplies	238,192	244,642	254,833	259,431	266,266	273,643
Infrastructure & non clinical supplies	178,025	189,826	186,307	193,095	199,860	205,266
Other	9,421	5,627	6,378	6,513	6,650	6,788
TOTAL EXPENDITURE	**1,344,857**	**1,401,756**	**1,422,482**	**1,457,982**	**1,500,910**	**1,543,884**
SURPLUS/(DEFICIT)	**(4,379)**	**(20,965)**	**0**	**0**	**(0)**	**(0)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	31,828	-	-	-	-	-
Cash flow hedges	(4,293)	552	552	552	552	552
TOTAL COMPREHENSIVE INCOME	**23,156**	**(20,413)**	**552**	**552**	**552**	**552**

The Provider Arm is forecasting a deficit for 2015/16, which will be fully absorbed by the Funder on consolidation. However, moving forward, the Provider arm is planning a breakeven position which is partly achieved via additional funding assumed and savings planned. Savings details have been included in the Annual Plan Financial template and are briefly described in this Annual Plan.

Governance and Funding Administration Arm Financial Performance

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Revenue from Funder Arm	**11,352**	12,234	11,733	12,125	12,516	12,908
Revenue Other	**32**	3	-	-	-	-
TOTAL INCOME	**11,385**	**12,237**	**11,733**	**12,125**	**12,516**	**12,908**
EXPENDITURE	13,238	8,432	11,733	12,124	12,516	12,908
SURPLUS/(DEFICIT)	**(1,854)**	**3,805**	**0**	**0**	**0**	**0**
TOTAL COMPREHENSIVE INCOME	**(1,854)**	**3,805**	**0**	**0**	**0**	**0**

The Governance and Funding Administration arm continues to perform within the funding allocated, with a forecast surplus/(deficit) for 2015/16 of $3,805K and for breakeven throughout the planning period.

Capital Expenditure

The Capital Intentions for the DHB have been included in the Annual Plan financial templates and are summarised in the table below. The capital plan included reflects the level of capital able to be funded from internally generated cash (mainly depreciation free cashflow). We are in the process of developing a comprehensive Long Term Investment Plan (LTIP). The LTIP will describe the major investments planned in the ten year horizon, key drivers for these and the planned financial plan (including Crown Equity, private sector leasing and donations). Ongoing capital investment is required to meet growth in services, compliance related investments and investments in information technology.

The Capital Plan summarised below reflects planned baseline capital projects and strategic capital projects that have been approved. Unapproved strategic projects are not included in the summary.

	2014/15 Audited $'000	2015/16 Forecast $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
FUNDING SOURCES						
Free cashflow from depreciation	41,373	45,495	47,474	52,705	55,830	58,928
External Crown Funding	-	-	-	-	-	-
Private Funding – Finance leases			4,900	5,550	6,550	5,750
Donations			-	-	-	-
Cash Reserves	24,021	14,740	18,493	4,034	(4,131)	(2,607)
TOTAL FUNDING	**65,394**	**60,235**	**70,867**	**62,289**	**58,249**	**62,071**
BASELINE CAPITAL EXPENDITURE						
Land	5,614	-	-	-	-	-
Buildings and Plant	23,268	32,464	23,698	21,151	20,017	26,603
Clinical Equipment	29,121	15,209	18,518	21,282	27,722	27,563
Other Equipment	2,384	1,736	2,212	272	-	-
Information Technology (Hardware)	111	15	-	-	-	-
Intangible Assets (Software)	616	380	9,566	4,489	3,739	3,701
Motor Vehicles	1,469	456	405	500	1,000	739
TOTAL BASELINE CAPITAL EXPENDITURE	**62,583**	**50,260**	**54,399**	**47,694**	**52,478**	**58,606**
STRATEGIC INVESTMENTS						
Land	-	-	-	-	-	-
Buildings & Plant	2,811	9,975	6,217	6,031	2,000	-
Clinical Equipment	-	-	6,318	2,591	2,821	3,265
Information Technology	-	-	-	-	-	-
Intangible Assets (Software)	-	-	3,933	5,973	950	200
TOTAL STRATEGIC CAPITAL EXPENDITURE	**2,811**	**9,975**	**16,468**	**14,595**	**5,771**	**3,465**
TOTAL CAPITAL PAYMENTS	**65,394**	**60,235**	**70,867**	**62,289**	**58,249**	**62,071**

Banking Facilities and Covenants

Term Debt Facilities

We have term debt facilities of $304.5M with the Ministry of Health which are fully drawn. All Auckland DHB debt is now with the Crown, following refinancing of private bonds in September 2015.

Shared Commercial Banking Services

Auckland DHB continues to participate in the shared banking arrangements in place with Westpac, other DHBs and New Zealand Health Partnership Limited (NZHPL). Under these arrangements, DHBs are not required to maintain separate overdraft or stand by facilities for working capital.

Together with all other DHBs, Auckland also elected to participate in the All of Government banking contract negotiated by MBIE.

Banking Covenants

Auckland DHB was subject to a Negative Pledge Deed with parties to the Deed being the Ministry of Health (as successors to the Crown Health Financing Agency), MBIA New York as insurer on behalf of the Bond holder, and the following banks: ANZ, BNZ, Westpac and CBA/ASB. Financial covenants were put in place as part of the Negative Pledge Deed and Auckland DHB reported on performance against the covenants on a 6 monthly basis. Following repayment of the $50M bonds and confirmation from the Ministry of Health and Westpac, Auckland DHB no longer has any covenant reporting obligations.

MODULE 5: Stewardship

Managing our business

In order to manage our business effectively and efficiently to deliver on the priorities and activities described in Modules 1 and 2, 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 is spent wisely and with the overall intention of improving, promoting and protecting the health of our population.

Organisational performance management

We have developed an organisational performance framework that links our high-level outcomes framework with day-to-day activity. The organisational performance monitoring processes in place include our Annual Report, 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 that 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 are meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. We continue to develop innovative ways to support the service delivery changes needed. Improving the effectiveness and efficiency of 'in-house' tasks frees resources for health care delivery.

Asset management

Asset management plan development

We have an Asset Management Plan (AMP) that helps to inform the capital requirements of the DHB in the short to long term. The AMP 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 plan also outlines the key strategic projects planned for the medium term.

Overall, the 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. The plan was fully updated in 2015, including high-level projections of how future health service demand would affect Auckland DHB's asset base. Since updating the AMP in December 2015, work has also started on developing a Clinical Services Plan (CSP) for the Auckland DHB Provider Arm in a two-staged process. The first stage, to be completed by June 2016, will articulate the services we are currently providing as well as projected growth in demand for these services in the short to medium term (a five-year view). This will also include asset impacts of this short-term growth, which will assist with prioritisation and defining timing of implementing medium-term projects. Thereafter, work on stage two involving a longer-term view of service growth and models of care will be developed. The AMP will continue to be updated to reflect any changes in asset requirements arising from planned service growth, capacity requirements and changes in models of care.

The AMP includes the long-term capital intentions, with more certainty around the short-term planned projects and less certainty for the longer-term projects, some of which are included as placeholders. We are also developing a separate Long Term Investment Plan for the DHB as part of the Investor Confidence

Rating process underway with New Zealand Treasury. This will include the drivers for, the timing, scope, costs and affordability of the capital inventions. The CSP work will assist in refining this.

We are working collaboratively with other northern region DHBs on implementing best practice capital processes, business case development principles and asset management practices across our DHBs. We continue to review and update our capital-related policies and procedures and the investment manual that incorporates some of the New Zealand Treasury Better Business Case development principles. We continue to work on improving our investment decisions to ensure that we are investing wisely and making the most of our limited capital funding to support the capital and infrastructure requirements of the health services we provide.

We also continue to work towards incorporating principles of best practice asset management planning into our business-as-usual processes. During 2016, we will be assessed for our asset management maturity level as part of the Investor Confidence Rating regime introduced by the New Zealand Treasury in response to the Cabinet Office Circular CO(15)5 "Investment Management and Asset Performance in the State Services". Work we completed during 2014 on self-assessment and independent review of our asset management maturity has helped us develop a detailed asset management improvement plan. This has been included in the AMP and is currently being implemented. The improvement initiatives planned and some under implementation include:

- **Addressing Asset Data Integrity and Quality Issues:** Improving the quality of our asset data and related processes will better inform our capital needs and decisions.
- **Clinical Equipment Asset Verification and Cataloguing:** We are currently implementing a high value clinical equipment verification project to improve the quality of our asset data and enable this to be more useful for ongoing maintenance and long-term investment planning.
- **Buildings Condition Assessments:** We have completed high-level condition assessments for all buildings owned by us as required by the Ministry's annual Asset Stock-take. The AMP includes scheduled renewal of all major building and plant items (e.g. roofs, boiler and chillers); the condition of these assets is regularly monitored by our Facilities Management. This is done by planned preventative maintenance checks scheduled in the BEIMS maintenance system, real-time monitoring of critical plant on the Building Management System and condition assessments undertaken by Facilities Management staff as major assets approach their scheduled renewal dates.
- **Seismic Compliance Assessment:** We have been active in improving seismic compliance since 1999 when our Seismic Risk Management Plan (SRMP) was first prepared. Since then, a number of buildings have been exited, strengthened or demolished. In 2012, an update of the SRMP was undertaken to reflect new standards and engineering techniques. IEP analysis was undertaken for all major pre-1995 buildings. Out of this, only one additional structure (apart from those already identified) was found to be in need of strengthening and this is currently underway.
- **Site Master Planning**: Work is ongoing around key strategic capital projects, with timing in the medium to long term, including consideration of financing options. CSP work underway will be useful to inform the scope, timing and cost of the long-term facilities renewals, upgrades and new builds.

Capital Investment

Auckland DHB continues to make improvements in maintaining and managing its existing asset base. This includes ensuring that replacements, refurbishments and upgrades are completed in a timely and affordable manner to enable us to continue to provide health services, meet compliance requirements and introduce new, appropriate and affordable technology. Affordability of both the capital spend and flow on impact on operational spend is a key consideration in investment decisions. Key considerations in the capital allocation process and timing of implementation of projects include managing risks relating to patients, staff, public, service provision, service capacity and technology changes.

Auckland DHB has put considerable effort into establishing a new clinically led organisational structure that identified single points of accountability for all aspects of managing service provision. Work is progressing on clinical services planning to model the demand growth for services, review the way we are providing services and work on new models of care that are more cost and/or clinically effective and sustainable operationally and financially in the long term. This work has and will continue to inform the

strategic capital priorities for the DHB for the next ten years and beyond. Work completed so far, including that from previous site master planning and asset management planning identified the Capital intentions for the next ten years shown in the table below (including placeholder projects).

Business cases are being developed for some of these to inform the scope, scale and costs. Projects that require Ministry of Health or Ministerial approval will follow the national capital investment approval process and those requiring DHB Board approval only will follow the regional capital approval processes.

We are currently developing our Long Term Investment Plan and this will further inform the capital intentions for the next ten years. In addition to baseline replacements across all asset classes, the following major projects are planned for the ten year planning horizon.

Major capital investment projects (>$10M and Unapproved)

Capital Intentions in $'000s	Estimated Total Capital Cost	Project Timeframes	Status
Integrated Cancer Centre	56,000	2016/17 – 2021/22	Business case under development
Endoscopy	15,000	2021/22 – 2023/24	Business case under development
Fraser McDonald	11,637	2016/17 – 2023/24	Business case under development
Renal	23,675	2016/17 – 2023/24	Business case under development
Stroke Service	13,000	2017/18 – 2019/20	Business case under development
Northern Electronic Health Record (NEHR)	90,351	2016/17 – 2021/22	Implementation Planning work underway to inform business case
NEHR Integration costs	15,000	2021/22 – 2025/26	Implementation Planning work underway to inform business case
Infrastructure Remediation Program	127,553	2016/17 – 2025/26	Planning work underway
Emergency Department	7,870	2016/17 – 2017/18	Business case under development
ACH Major Refurbishments	40,000	2022/23 – 2021/22	Strategic placeholder
GCC Major Refurbishments	18,000	2022/23 – 2024/25	Strategic placeholder
GCC Extra Floor	8,000	2022/23 – 2023/24	Strategic placeholder
Parking	19,400	2016/17 – 2022/23	
Total Project Costs	**445,486**		

Emergency management

Our Emergency Management Service leads the co-ordination all activities required by Auckland DHB and regional partners to comply with all legislative and Ministry of Health requirements in preparing for, managing, and recovering from any emergency that may arise.

The Emergency Management Service promotes a hazards and risk based model of comprehensive emergency management, which focuses on building resilience and the continuity of operations. This approach includes active participation across the wider civil defence sector at national, regional, and local levels, and includes the provision of training and resources to all levels of staff to increase the organisational knowledge of emergency management.

Building Capability

National and regional programmes

We will contribute to the achievements of clinically led, regional networks as they progress the objectives of the Northern Region Health Plan. This work places particular emphasis on:

- Agreement of appropriate standards and the consistency of care delivery across our region
- Development of new models of care to achieve the best clinical outcomes and efficient use of the region's health resources

- The use of information technology to enable integrated and patient- and whānau-determined health; crossing organisational boundaries and extending along the continuum of care.

We will also contribute to the achievement of the Health Promotion Agency, Health Quality and Safety Commission, Health Workforce New Zealand, and National Health IT Board objectives, including:

- Support national Health Promotion Agency activities around the health targets, provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy, and alcohol screening and brief intervention
- Meet infection control expectations in accordance with the Operational Policy Framework for the surgical site infection programme, capability and leadership; continue to develop infection management systems at the DHB level
- Support the implementation of national IT initiatives, such as the National Maternity Information System Platform, electronic Prescribing and Administration, regional applications and roadmap to deliver capabilities, participate on regional advisory groups, and commit to regional implementation to deliver the CWS, CDR and PAS regional capabilities.

The DHB will commit resources to the implementation of the approved NZHPL Finance, Procurement and Supply Chain (FPSC) initiative, and fully factor in expected budget benefit impacts where these are deemed achievable within planned timeframes.

The Auckland DHB will work collaboratively with the MoH to solve sector issues by:

- Engaging with and providing advice on prioritisation and assessments, including through the National Prioritisation Reference Group
- Referring technologies that drive fast-growing expenditure to the MoH for prioritisation and assessment where appropriate
- Consistently introducing or not introducing emerging technologies based on the MoH recommendations
- Holding technologies, which may be useful, but for which there is insufficient evidence, or which the MoH is assessing for further diffusing or out of business as usual
- Providing clinical and business expertise and research time to design and run field evaluations where possible.

Auckland DHB commits to work with the Ministry of Health on the work programme of the former National Health Committee (once this is finalised).

Building IT capacity

Effective information systems are a fundamental enabler of the Northern Region's whole-of-system approach to health service delivery. The direction on information management, systems and services in the Northern Region is set by the Northern Regional Information Strategy (RIS 2010–20).

Auckland DHB recognises that the direction of IT investment is led by strong business and clinical architecture. This year, the governance focus with our regional partners will be on:

- Continuing to strengthen our shared information service, with a focus on responsiveness and value
- Participating in national initiatives including planning for the National Health Plan and the National Infrastructure Platform
- Development of the business case for a regional electronic health record, in parallel with a refresh of the RIS10–20
- Continuing investments in electronic support of care models that are closer to the patient.

Auckland's stewardship focus this year is on continuing to embed strong district-wide ownership of our IT investment plan and supporting the clinically led initiatives to co-design and integrate care models across the district.

Quality and safety

Enabling health and wellbeing through high quality health and healthcare services is our organisation's core purpose. At Auckland DHB, we are committed to empowering patients, families and whānau to take more control of their health and healthcare, to empower staff to make a difference as well as having an ongoing commitment to innovation, education and research.

We define quality as care that is safe, effective, efficient and equitable and which provides a positive patient experience. Our vision – healthy communities, world-class healthcare, achieved together – places quality as a central priority of the DHB.

Key to this is a system-wide work programme enabling the delivery of reliable, safe, high quality care every hour of the day. We aim for a robust safety culture where the patient is at the centre, in an environment where high performing teams deliver excellent care, where data informs practice and variation is minimal. Specific actions are included in Module 2B 'Patient Experience' and 'Improving Quality'. As part of our system-wide improvement programme, two major programmes are in progress:

- Recognition and safe care of the deteriorating patient
- 24/7 high quality care, with particular focus on safe after-hours care.

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. Any critical issues are escalated if necessary.

Workforce

Managing our workforce within fiscal restraints

Living within our means is central to our success as an organisation. Auckland DHB works with the DHB Shared Services employment relations function to inform the national Employment Relations Strategy Group (ERSG). This group establishes the national parameters to ensure all national bargaining will deliver both organisational and sector expectations. Any agreements negotiated nationally, regionally or locally are approved by the Ministry of Health, as per established protocols. Auckland is particularly impacted by the very large number of people in training and the costs associated with this. Capacity to maintain this will be evaluated. In addition, Auckland DHB has increasing demand for its services and will continue to focus on the allocation of its resources and the reliable implementation of employment terms and conditions.

Strengthening our workforce capacity

We will work with our regional partners to develop and implement regional workforce strategies with a focus on government priority areas and targets, and internally to strengthen our workforce in relation to Culture, Capability, Capacity and Change Leadership. The DHB supports the regional approach to expand and/or implement nurse practitioners, clinical nurse specialists, palliative care nurses, and nurse specialist palliative care educator and support roles, as well as specialist nurses to perform colonoscopies, and recruit Medical Physics registrars to reduce the vulnerability of a small and critical workforce. We will continue to contribute to and work with the region over the regional sonography training programme. Working in conjunction with the Medical Council of New Zealand and primary and community-based practices, we will ensure that pre-vocational trainees have access to community-based attachments.

We will also work with the Regional Training Hub Director to develop and deliver a workforce plan as part of the 2016/17 Regional Service Plan. The workforce plan will outline regional actions, key milestones and will reflect our approach to meeting Health Workforce New Zealand expectations.

We will plan for our demographic and model of care changes and use the workforce intelligence and forecasting tools. We will grow our Māori workforce from 3.4% to 13% in all areas by 2020.

Our current workforce

FTE	Other	Pacific	Māori	TOTAL
Administration	1,061	116	64	1,241
Allied Health	1,637	118	80	1,834
Nursing	2,950	309	96	3,354
RMO	559	13	11	583
SMO	805	4	8	817
Support	280	72	13	365
Other	3			3
Total	**7,294**	**632**	**271**	**8,197**

Headcount	Other	Pacific	Māori	TOTAL
Administration	1,203	130	74	1,407
Allied Health	2,026	129	86	2,241
Nursing	3,939	397	125	4,461
RMO	620	15	14	649
SMO	1,030	6	9	1,045
Support	335	82	17	434
Other	6			6
Total	**9159**	**759**	**325**	**10,243**

Headcount excludes casual staff. Sourced from Leader, accurate as at 27 January 2016

Note: some services are jointly provided for both Auckland and Waitemata DHBs, though hosted and employed by Waitemata DHB.

Strengthening our workforce culture

Our workforce is central to the delivery of the organisational vision of a healthy local population and quality health services across the continuum when people need it. We are committed to building and maintaining a performance- and patient-focused culture where we work with and empower our patients and families in their care delivery. This culture change is our top priority and work is underway to review and refresh our values, involving all our staff.

We will focus on:

- attraction and retention – by developing healthy workplaces activity, promoting cultural diversity and programmes to ensure our people consistently experience and live our values
- capacity and capability – ensuring Auckland DHB staff have the capacity and capability to achieve the DHB's strategic aims and support the cultural programmes for Māori, Pacific and Asian workforces that improve access/engagement and health outcomes
- values – developing a programme to embed organisational awareness and ability to demonstrate our values and articulating our expected standards and behaviours
- leadership and management – implement structured leadership development to enhance and evolve the culture at Auckland DHB whilst supporting the new operating model roll out.

Organisational health

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. We are equally aware that good employment practises are a critical aid in the building of a reputation that attracts and retains top health professionals who embody our values and patient-centred culture in their practice and contribution to organisational life.

Our Good Employer policy makes clear that we will:

- recognise the aims, aspirations and employment requirements of Māori people
- recognise the aims, aspirations, cultural differences and employment requirements of Māori and Pacific Island people and people from other ethnic or minority groups

- provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- ensure that employees maintain proper standards of integrity and conduct in accordance with our values
- provide a healthy and safe workplace
- provide recruitment, selection and induction processes that recognise the employment requirements of women, men and persons with disabilities
- provide opportunities for individual employee development and career advancement.

Health and safety

At the Auckland District Health Board the health and safety of the workers, patients and others utilising our facilities and services is paramount. Our health, safety and wellbeing aspiration is expressed in the Auckland DHB Health and Safety Board Charter:

A safe environment for everyone.
A culture of excellence in health and safety performance.

We aim high to have a safe environment for our people, patients and visitors, contractors, where our health and safety obligations, risk and harm is understood, regularly discussed, assessed, and addressed. We are committed to the development of a positive health and safety culture, providing safe and secure facilities, providing the training needed to ensure workers can keep themselves safe in our workplace, understanding our hazards and reducing our risks, driving down injury rates and fully supporting any workers who experience an injury in our workplace.

This year we plan to increase our level of leadership, commitment and performance by:

1. Ensuring that the organisation is ready for the change in the new health and safety legislation
2. Educating all Auckland DHB workers in the changes of the new Health and Safety at Work Act 2015
3. Dealing with key health and safety risks promptly, using risk based approaches in a way that sustains safe workplace practices
4. Identifying opportunities to enhance the wellbeing of our staff
5. Refining our process to support our health and safety representatives to meet the new legislative requirements
6. Implementing a new Board report and reviewing our key leading and lagging indicators to be able to continually improve our reporting mechanism
7. Working collaboratively with the Northern Region on appropriate regional Health and Safety risks, which will include procurement, public health promotion and employee strategies
8. Continuing to review and improve our current health and safety systems and processes through internal and external auditing
9. Progressing the work streams identified in the Security for Safety Project and implementing the recommended outcomes
10. Developing improved health and safety visibility in building project design and pre-occupation inspection
11. Embedding Health and Safety into our workplace culture and applying learnings across the organisation.

Reporting and consultation

We will provide the Ministry of Health with information that enables monitoring of performance against any agreement between the parties and provide 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 Report and audited financial statements
- Quarterly reports
- Monthly reports

- Any ad hoc information that the Minister or Ministry require.

Ability to enter into service agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Auckland DHB is permitted by this Annual Plan to:

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

We have no plans to enter into a body co-operative agreement or arrangement, or to acquire shares or interests in any body corporate, trust, joint venture partnership and/or other association of persons, to settle or appoint a trustee of a trust, and any processes to be followed and requirements to consult with the Minister.

Memoranda of Understanding

We hold a Memoranda of Understanding (MOU) with Te Rūnanga o Ngāti Whātua, which outlines 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.

MODULE 6: Service Configuration

Service coverage exceptions and service changes must be formally approved by the Ministry of Health prior to being undertaken. In this section, we signal emerging issues.

Service coverage and service change

Regional Service Change

Health services are continually evolving. Having a strong regional focus has successfully reduced the number of services identified as 'vulnerable' in terms of workforce, capacity and demand. We are changing the focus toward service planning and development to reflect the support given by DHB Chairs, clinical leaders and management to shape how services are structured and delivered in an environment of greater regional co-operation.

The key regional service change that has been signalled in prior years is the implementation of a Supra Regional Eating Disorders Services (EDS) Hub. Key changes that will be implemented in 2016/17 include:

- Auckland DHB will progress co-location of services comprising the fully integrated Auckland DHB-managed EDS Hub which will result in seamless transitions for clients between services
- A comprehensive training and support schedule will support supra regional workforce development and enhance local service delivery
- Exploring the use of technology to enhance client access to specialist support
- Extending the range of services where there is evidence of effectiveness (e.g. the introduction of multi-family therapy).

We will continue to work in the direction set by the DHB Chairs that our region will promote rational regional service distribution to:

- Strengthen the region overall
- Create the opportunity for certain services to be delivered locally
- Not destabilise any particular DHB.

The moratorium on service repatriation will continue. In the place of service repatriation, we will ensure a service distribution process that is rational, collaborative, enabling and able to be achieved in as short a time as possible.

The vision is that the current service providers will continue to hold the funding (through IDFs) and the key staff for the service mix currently being delivered for different DHB populations but will provide the service in an appropriately agreed and distributed way for each of our DHBs.

In line with the national initiative and recent guidelines to maximise the wellbeing of our population living with hepatitis C, we will support the design and implementation of a single clinical pathway for hepatitis C across the Northern Region to provide consistent services. This includes data capture of the key performance measures of patients diagnosed with hepatitis C and those having a fibroscan within the last year. At a DHB level, we will: work with our District Alliance and other stakeholders to ensure a whole-of-system approach and strong clinical leadership to implement integrated services; raise community and GP awareness and education; provide quality and accessible identification, assessment and management; and support the involvement of clinical nurse specialists in care delivery.

Local oncology service delivery where we will investigate the options for transitioning some high volume Medical Oncology service elements away from the Northern Region Tertiary centre (Auckland DHB), and into regional secondary and community based delivery. Locations/facilities to be considered are within Northland, Waitemata and Counties Manukau DHBs.

Local Service Change

Type of service change	DHB	Area impacted by service change	Description of service change
Gap in service delivery	Auckland DHB Waitemata DHB	Smoking cessation services: • Pacific Quit Service (delivered by ARPHs) • Elective service (delivered by Waitemata DHB provider-arm) • Pregnancy Smoking Cessation Service (delivered by Auckland DHB provider-arm) • Waitemata DHB Community Pharmacy Smoking Cessation services (19 community pharmacies) • Smokefree Whānau service (delivered by Waitemata PHO)	The Ministry of Health (MOH) is undertaking a realignment of stop smoking services and all current stop smoking services (except Quitline) are ending on 30 June 2016. The MoH are appointing new providers and implement a new service delivery model. This means that the DHB will be required to align Tabaco control contracts with the new model of provision.
Change in model of service delivery	Auckland DHB Waitemata DHB	Home and Community Support Services (HCSS)	Procurement for this service will commence within 2016/17
Potential change in model of service delivery	Auckland DHB Waitemata DHB	Community Pharmacy	DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and a range of other stakeholders to develop service options This includes local engagement with consumers and other stakeholders on potential options for pharmacist service delivery
Potential change of provider	Auckland DHB Waitemata DHB	Active Families	Contracts will be re-tendered prior to their expiry on 30 June 2017 as the current providers have held these contracts since the late 1990s
Level, location and configuration of services	Auckland DHB Waitemata DHB	Maternity services	Subject to consultation feedback in Waitemata DHB and Board decisions, additional primary maternity facilities may be commissioned. Changes may be made to maternity facilities in Auckland DHB to increase primary births, following Board decisions. Subject to Board approvals, an RFP process may be run to include existing facilities in Auckland DHB

Type of service change	DHB	Area impacted by service change	Description of service change
Change in service provider/s and configuration of services	Auckland DHB Waitemata DHB	Oral health – relief of pain services	New contracts expected to be entered into during 2016/17, following RFP process Also, explore the possibility of shifting relief of pain services for adults out of the hospital service to community dental providers based in high needs locations
Change in configuration of services and possible change in service provider/s	Auckland DHB Waitemata DHB	Immunisation and Outreach Services	Review of the configuration of immunisation and outreach services during 2016/17 and possible changes to the configuration of service and/or the provider/s of services from 17/18
Potential changes of providers and configuration of services	Auckland DHB Waitemata DHB	Community Services	In line with the Government's Rules of Sourcing, the DHBs will be undertaking open procurement processes as contracts expire. This has the potential to affect providers of services listed above plus a range of other service providers/services including (but not limited): - National Immunisation and Outreach Services - B4 School Checks
Change in model of service delivery	Auckland DHB	Outpatient services	Services are expected to reduce high volumes of face-to-face outpatient activity and replace this with alternative methods of delivery such as Virtual, Telemedicine and Nurse-led provision
Level and configuration of services	Auckland DHB	Tertiary services	Auckland DHB will be reviewing the specification and cost of tertiary services. Findings may impact on the configuration and scope of some services

MODULE 7: Performance Measures

Monitoring framework performance measures

The following table presents the full suite of Ministry of Health 2016/17 non-financial reporting indicators, excluding health targets. This section is a Ministry requirement, but many of these measures appear elsewhere in the Annual Plan, as much of our work is centred on government priorities and these measures are a useful way of monitoring progress and achievement.

Performance measure	2016/17 Performance expectation/target			DHB target	
PP6: Improving the health status of people with severe mental illness through improved access	**Age 0-19**			3.0%	
	Age 20-64			10%	
	Age 65+			3.1%	
PP7: Improving mental health services using transition (discharge) planning	Long-term clients	Provide a report each quarter as specified in the measure definition			
	Child and youth with a transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan		≥95%	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19	80%	95%	80%	95%
	Addictions (Provider Arm and NGO)				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19	80%	95%	80%	95%
PP10: Oral Health - Mean DMFT score at Year 8	Ratio year 1			0.85	
	Ratio year 2			0.82	
PP11: Children caries-free at five years of age	Ratio year 1			70%	
	Ratio year 2			72%	
PP12: Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	% year 1			85%	
	% year 2			85%	
PP13: Improving the number of children enrolled in DHB-funded dental services	0-4 years - % year 1			95%	
	0-4 years - % year 2			95%	
	Children not examined 0-12 years - % year 1			6%	
	Children not examined 0-12 years - % year 2			6%	
PP20: Improved management for long-term conditions (CVD, Acute heart health, Diabetes and Stroke)					
Focus area 1: Long-term conditions	Report on delivery of the actions and milestones identified in the Annual Plan				
Focus area 2: Diabetes services	Reporting on implementation of actions in the Diabetes plan 'Living Well with Diabetes'				
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator)				
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years			90%	
	Indicator 2: 90 percent of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years			90%	
	Report on delivery of the actions and milestones identified in the Annual Plan				
Focus area 4: Acute heart service	70 percent of high risk patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') by ethnicity			70%	
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days			>95%	

Performance measure	2016/17 Performance expectation/target	DHB target
	Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge	>95%
	Report on deliverables for acute heart services identified in Annual Plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI	
Focus area 5: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage (previous health target)	Percentage of two year olds fully immunised	95%
	Percentage of five year olds fully immunised	95% by June 2017
	Percentage of eligible girls fully immunised - HPV vaccine	70% for dose 3 (2003 birth cohort at June 2017)
PP22: Improving system integration and SLMs	Report on delivery of the actions and milestones to improve integration identified in Annual Plans In relation to SLM measures - a jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	100%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long-term care facility (LTCF) assessment completed within 230 days of the previous assessment	75%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long-term care facility (LTCF) assessment	98%
PP25: Prime Minister's youth mental health project	*Initiative 1*: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities 1. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided 2. Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: a framework for continuous quality improvement in each school (or group of schools) with SBHS *Initiative 3:* Youth Primary Mental Health 1. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Māori, Pacific and low decile youth populations 2. Provide quantitative reports using the template provided under PP26 *Initiative 5*: Improve the responsiveness of primary care to youth	

Performance measure	2016/17 Performance expectation/target		DHB target
	1. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements 2. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme		
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: • Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis Response Services • Improve outcomes for children • Improving employment and physical health needs of people with low prevalence conditions		
PP27: Support of vulnerable children	Report on delivery of the actions and milestones identified in the Annual Plan		
PP28: Reducing Rheumatic fever	Provide a progress report against DHB's rheumatic fever prevention plan		
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic		1.1 per 100,000
	Report on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever		
PP29: Improving waiting times for diagnostic services	1. Coronary angiography: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)		95%
	2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)		95% for CT scans 85% for MRI scans
	3. Diagnostic colonoscopy a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days, inclusive), 100% within 30 days b. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days		85% within 14 days 100% within 30 days 70% within 42 days 100% within 90 days
	Surveillance colonoscopy c. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days		70% within 84 days 100% within 120 days
PP30: Faster cancer treatment	Part A: Faster cancer treatment – 31 day indicator	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	85%
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat	100%
PP31: Better help for smokers to quit in public hospitals	95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking		95%
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age group 0-4 years (SLM measure)	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones and target, will be	

Performance measure	2016/17 Performance expectation/target		DHB target
		provided at the end of quarter one 2016/17 via measure PP22	
	Age group 45-64 years	3,204/100,000	
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region		
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry)		
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	An intervention rate of 21.0 per 10,000 of population	21.0 per 10,000
	Cataract procedures	An intervention rate of 27.0 per 10,000 of population	27.0 per 10,000
	Cardiac surgery	A target intervention rate of 6.5 per 10,000 of population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate	6.5 per 10,000
	Percutaneous revascularisation	A target rate of at least 12.5 per 10,000 of population	12.5 per 10,000
	Coronary angiography services	A target rate of at least 34.7 per 10,000 of population	34.7 per 10,000
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: • Mental health • Asthma • Oral health • Obesity • Tobacco and narrative reports cover all areas indicated		
SI7: SLM total acute hospital bed days per capita	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22		
SI8: SLM patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22	
	Primary care	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22	
SI9: SLM amenable mortality	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22		
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.55 days, which represents the 75th centile of national performance	1.55 days
	Acute LOS	The suggested target is 2.35 days, which	2.35 days

Performance measure	2016/17 Performance expectation/target	DHB target
	represents the 75th centile of national performance	
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition under review	TBC
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus area 1: Improving the quality of identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	>2% and ≤4% >1% and ≤3% >1.5% and ≤6%
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	>0.5% and ≤2%
	Validated addresses unknown Greater than 76% and less than or equal to 85%	>76% and ≤85%
	Invalid NHI data updates (no confirmed target)	MoH TBC
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	≥97% and <99.5%
	National collections file load success Greater than or equal to 98% and less than 99.5%	≥98% to <99.5%
	Assessment of data reported to the NMDS Greater than or equal to 75%	≥75%
	NNPAC timeliness Greater than or equal to 95% and less than 98%	≥95% and <98%
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a. 5 percent variance (+/−) of planned volumes for services measured by FTE b. 5 percent variance (+/−) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c. actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services	No performance target/expectation set	
Developmental measure DV7: SLM number of babies who live in a smokefree household at six weeks postnatal	No performance target/expectation set	

MODULE 8: Appendices

Appendix 1: DHB Board and management

DHB governance is provided by a Board of eleven people, seven of whom are elected and four of whom are appointed by the Minister of Health. Board members provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and its current priorities.

Board members	Dr Lester Levy, Chair	(appointed)
	Dr Lee Mathias, Deputy Chair	(elected)
	Jo Agnew	(elected)
	Peter Aitken	(elected)
	Douglas Armstrong	(elected)
	Judith Bassett	(elected)
	Dr Chris Chambers	(elected)
	Robyn Northey	(elected)
	Gwen Tepania-Palmer	(appointed)
	Morris Pita	(appointed)
	Ian Ward	(appointed)

In 2014, Auckland District Health Board adopted a clinical single point of accountability model across its provider arm. The provider is now organised into ten Directorates, each led by a Director (a clinician) who is the single point of accountability for the directorate. These changes are driving performance improvement through better alignment of portfolios and significantly enhanced clinical leadership.

Senior leadership team for Auckland DHB	Ailsa Claire	Chief Executive
	Dr Margaret Wilsher	Chief Medical Officer
	Margaret Dotchin	Chief Nursing Officer
	Sue Waters	Chief Health Professions Officer
	Naida Glavish	Chief Advisor Tikanga (Auckland and Waitemata DHBs)
	Rosalie Percival	Chief Financial Officer
	Fiona Michel	Chief of People and Capability
	Linda Wakeling	Chief of Intelligence and Informatics
	Dr Andrew Old	Chief of Strategy, Participation and Innovation
	Joanne Gibbs	Director of Provider Services
	Dr Debbie Holdsworth	Director of Funding (Auckland and Waitemata DHBs)
	Simon Bowen	Director of Health Outcomes (Auckland and Waitemata DHBs)
	Bruce Levi	General Manager, Pacific Health (Auckland and Waitemata DHBs)
Children's Directorate	Dr Michael Shepherd	Director
Mental Health and Addictions Directorate	Dr Clive Bensemann	Director
Adult Medical Services Directorate	Dr Barry Snow	Director
Adult Community and Long Term Conditions Directorate	Judith Catherwood	Director
Cancer and Blood Directorate	Dr Richard Sullivan	Director
Perioperative Services Directorate	Dr Vanessa Beavis	Director
Surgical Services Directorate	Dr Wayne Jones	Director
Cardiac Directorate	Dr Mark Edwards	Director
Women's Health Directorate	Dr Susan Fleming	Director
Clinical Support Services Directorate	Ian Costello	Acting Director

Appendix 2: Significant Accounting Policies

The forecast financial statements have been prepared on the basis of the significant accounting policies which are expected to be used in the future for reporting historical financial statements. The significant accounting policies used in the preparation of these forecast financial statements included in this Annual Plan are summarised below. A full description of accounting policies used by Auckland DHB for financial reporting is provided in the Annual Reports that are published on the Auckland DHB website: www.adhb.govt.nz/publications.

Reporting Entity

The Auckland District Health Board (Auckland 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. Auckland DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes. Auckland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

The forecast consolidated financial statements include the DHB and its subsidiary and interest in associates and jointly controlled entities. The forecast consolidated financial statements of Auckland DHB comprise Auckland DHB and its subsidiary (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities. The Auckland DHB group consists of the parent, Auckland DHB and Auckland District Health Board Charitable Trust (controlled by Auckland DHB). Joint ventures are healthAlliance N.Z. Limited (25%) and NZ Health Innovation Hub Management Limited (25%). Associates are Northern Regional Alliance Limited (33.3%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

Basis of Preparation

The forecast financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The forecast 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). These forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*. These forecast financial statements comply with Public Sector PBE accounting standards. The forecast financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Presentation currency and rounding

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

Forecast Information

In preparation of the forecast financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results. The forecast financial statements for the year ended 30 June 2016, incorporate the unaudited results of the 10-month period to 30 April 2016.

Standards issued that are not yet effective and not early adopted

In 2015, the External Reporting Board issued Disclosure Initiative (Amendments to PBE IPSAS1), 2015 Omnibus Amendments to PBE Standards, and Amendments to PBE Standards and Authoritative Notice as a Consequence of XRB A1 and Other Amendments. These amendments apply to PBEs with reporting periods beginning on or after 1 January 2016. Auckland DHB will apply these amendments in preparing its 30 June 2017 financial statements. Auckland DHB expects there will be no effect in applying these amendments.

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Auckland DHB. Control exists when Auckland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust and has control. Consistent accounting policies have been used for both Auckland DHB and the Charitable Trust. Subsidiaries are consolidated from the date on which control is obtained by the group and cease to be consolidated from the date on which control is transferred out of the group. In preparing the consolidated forecast financial statements, all intercompany balances and transactions, revenue and expenses and profit and losses resulting from intra-group transactions have been eliminated in full. The investment in subsidiaries is carried at cost in Auckland DHB's parent entity forecast financial statements.

Joint Ventures

A joint venture is an entity over whose activities Auckland DHB has joint control, established by a binding agreement. The consolidated forecast financial statements include Auckland DHB's joint interest in the joint venture, using the equity method, from the date that joint control commences until the date that joint control ceases. There are no differences in accounting policies between the parent and joint venture entities. Treaty Relationship Company Limited is a joint venture company (50% investment in 2014 only) with Te Runanga O Ngati Whatua. Originally created as a vehicle through which to channel joint health related activities, it has not undertaken any business for some years and was struck off the Companies Register on 22 May 2015.

healthAlliance N.Z. Limited is a joint venture company that exists to provide a shared services agency to the four northern DHBs (25% each) in respect to information technology, procurement and financial processing.

NZ Health Innovation Hub Management Limited

The four largest District Health Boards (Counties Manukau, Auckland, Waitemata 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 healthcare in New Zealand and internationally. The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding in the limited partnership and the general partner, New Zealand Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

Associates

Associates are those entities in which Auckland DHB has the power to exert significant influence, but not control, over the financial and operating policies. Auckland DHB holds a 33% shareholding in Northern Regional Alliance Limited (NRA). Associates are accounted for at the original cost of the investment plus Auckland DHB's share of the change in the net assets of associates on an equity accounted basis, from the date that the power to exert significant influence commences until the date that the power to exert significant influence ceases. When Auckland DHB's share of losses exceeds its interest in an associate, Auckland DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Auckland DHB has incurred legal or constructive obligations or made payments on behalf of an associate. There are no differences in accounting policies between the parent and associate entities. NRA is an associate with Auckland, Counties Manukau and Waitemata DHBs. It exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs and to provide a shared services agency to the Northern Region DHBs in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

Summary of Significant Accounting Policies

Revenue

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

Revenue items	Explanation
MoH revenue	The DHB is primarily funded through revenue received from the Ministry of Health. This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder. Funding is recognised at the point of entitlement if there are conditions attached to the funding. The fair value of revenue from the Ministry of Health has been determined to be equivalent to the amounts due in the funding arrangements
ACC contract 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 Auckland DHB region is domiciled outside of Auckland. The Ministry of Health credits Auckland DHB with a monthly amount based on estimated patient treatment for non-Auckland residents within Auckland. An annual wash up occurs (in agreed areas) at year end to reflect the actual non Auckland patients treated at Auckland DHB
Donated services	Certain operations of the DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB
Income from grants	Income from grants includes grants given by other charitable organisations, government organisations or their affiliates. Income from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as income received in advance and recognised as revenue when conditions of the grant are satisfied
Research income	Research costs are recognised in the Statement of Comprehensive Revenue and Expense as incurred. Revenue received in respect of research projects is recognised in the Statement of Comprehensive Revenue and Expense in the same period as the related expenditure. Where requirements for Research income have not yet been met, funds are recorded as income in advance. The Trust receives income from organisations for scientific research projects, under PBE IPSAS 9 funds are recognised as revenue when the conditions of the contracts have been met. A liability reflects funds that are subject to conditions that, if unfulfilled, are repayable until the condition is fulfilled
Interest revenue	Interest revenue is recognised using the effective interest method
Rental revenue	Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the

Revenue items	Explanation
	lease term
Provision of services	Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date, based on the actual service provided as a percentage of the total services to be provided.
Donations and bequests	Donations and Bequests are received from the general public to be used for the general purpose of the Trust or for a specific programme or service. Donations and Bequests are recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Donations and Bequests are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the donation are not met. If there is such an obligation, the donations are initially recorded as income received in advance and recognised as revenue when conditions of the donation or bequest are satisfied

Capital charge

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

Borrowing costs

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

Foreign currency transactions

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

Leases

Finance leases

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

Operating leases

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

Cash and cash equivalents

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

Receivables

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

Investments

Bank term deposits

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

DHB bond FRA

Auckland DHB uses Bond Forward Rate Agreements (Bond FRAs) to hedge interest rate repricing risk inherent in the maturity profile of its underlying Debt portfolio. Bond FRAs are initially recognised at fair value on the date the contract is entered into, and are subsequently re-measured at the fair value at each balance date. Where considered appropriate, Auckland DHB applies hedge accounting to achieve the intention of Bond FRAs entered into. The Bond FRA settlement position is recognised as a cash flow hedge reserve in other comprehensive revenue and expense and amortised in the Statement of Revenue and Expense over the term of the underlying debt instrument.

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

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 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 (including fit outs and underground infrastructure); leasehold Improvements; plant, equipment and vehicles; and work in progress.

Owned Assets

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses. The cost of property, plant and equipment acquired in a business combination is their fair value at the date of acquisition.

Revaluations

Land and buildings and underground infrastructure are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis. The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to a property revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

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

Disposals

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

Subsequent costs

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

Depreciation

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

• Buildings (including components)	4-137 years	0.73–25%
• Plant, equipment and vehicles	5–20 years	5.00–20%
• Leasehold improvements	5 years	20%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

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.

Business combination and goodwill

Business combinations are accounted for using the acquisition method. The acquisition method involves recognising at acquisition date, separately from goodwill, the identifiable assets acquired and the liabilities assumed. The identifiable assets acquired and the liabilities assumed are measured at their acquisition date fair values.

When the Group acquires a business, it assesses the financial assets and liabilities assumed for appropriate classification and designation in accordance with the contractual terms, economic conditions, the Group's operating or accounting policies and other pertinent conditions as at the acquisition date.

Goodwill is initially measured at cost, being the excess of the aggregate of the consideration transferred and the amount recognised for non-controlling interests over the net identifiable assets acquired and liabilities assumed. After initial recognition, goodwill is measured at cost less accumulated amortisation and any accumulated impairment losses.

Amortisation

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

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

- Acquired software 3 to 5 years (20–33%)
- Internally developed software 3 to 5 years (20–33%)
- Goodwill 29 months (42%)

Indefinite life intangible assets are not amortised.

National Oracle Solution (NOS)

The NOS (previously FPSC) rights represent the DHB's right to access, under a service level agreement, shared NOS services provided using assets funded by the DHBs. The intangible asset is recognised at the cost of the capital invested by the DHB in the NOS Programme, a national initiative, facilitated by New Zealand Health Partnerships Limited (NZHPL) (previously Health Benefits Limited (HBL)), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services. The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation on the NOS assets to the DHBs will be used to, and is sufficient to, maintain the NOS assets standard of performance or service potential indefinitely. As the NOS rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

Non-cash generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information. If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value.

Borrowings

Borrowings on commercial terms are initially recognised at the amount borrowed plus transaction costs. Interest due on the borrowings is subsequently accrued and added to the borrowing balance. Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee entitlements

Short-term employee entitlements

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

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences. A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

Long-term entitlements

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme. Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

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

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. Future operating costs are not provided for.

ACC Accredited Employers Programme

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC. The liability for the ACC Accredited Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components: contributed capital; accumulated surplus/(deficit); reserves-property revaluation and cashflow hedge and trust funds.

Reserves

The property valuation reserve is related to the revaluation of land and buildings to fair value. The cashflow hedge reserve relates to the hedge accounting treatment for the Bond FRA settlement position.

Trust funds

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

Goods and services tax

All items in the forecast 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.

Cost allocation

The DHB has determined the cost of outputs using the cost allocation system outlined below. Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output. There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

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

Estimating the fair value of land and building revaluations

The most recent valuation of land and buildings was performed by an independent registered valuer, Evan Gamby (M PROP STUD Distn, DIP UV, FNZIV (Life), LPINZ, FRICS) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2015.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. All titles other than those relating to 50 Grafton Road are noted by certificate 9918215.1 as being subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act 2014 ("The Act") that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act (which restricts disposal, including leasing of the land).

Values have been adjusted to reflect the imposition of Section 148 of The Act. Restrictions on Auckland DHB's ability to sell land would normally not impair the value of the land because Auckland DHB has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

Buildings

Buildings, fit outs and infrastructures were last revalued on 30 June 2016 by Telfer Young (Auckland) Ltd.

Specialised buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.

- For Auckland DHB's earthquake-prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. Market rents and capitalisation rates were applied to reflect market value.

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

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

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

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

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

Retirement and long service leave

The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability. Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements.

Critical judgements in applying accounting policies

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

Leases classification

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

Agency relationship

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

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

Glossary

ACC	Accident Compensation Commission
Aiga Challenge	Aiga is Samoan for family. This is an 8-week weight loss challenge across Pacific churches/groups within HVAZ (Auckland DHB) and Enua Ola (Waitemata DHB) programmes
ALOS	Average Length of Stay
AOD	Alcohol Other Drugs
ARDS	Auckland Regional Dental Service
ASH	Ambulatory Sensitive Hospitalisations
BSA	Breast Screen Aotearoa
CADS	Community Alcohol, Drug and Addictions Service
CAMHS	Child, Adolescent Mental Health Service
COPD	Chronic Obstructive Pulmonary Disorder
CT	Computerised Tomography
CVD	Cardiovascular disease
DNA	Did Not Attend
DSME	Diabetes Self Management and Education
EBI	Effective Brief Intervention
ENT	Ear, Nose and Throat specialty
ESPI	Elective Services Patient Flow Indicators
FSA	First Specialist Assessment (outpatients)
FTE	Full Time Equivalent
GNS	Gerontology Nurse Specialist
GP	General Practitioner
He Kāmaka Waiora	A spiritual foundation of wellness
He Puna Waiora	A pool of wellness
HEADSS assessment tool	A child and youth health assessment tool that considers: home environment, education/employment/eating and exercise, activities and peer relationships, drug use/depression/mood, sexuality/safety and spirituality
HOP	Health of Older People
HVAZ	Healthy Village Action Zone
ICU	Intensive Care Unit
Iwi	Tribe
Kaiāwhina	Support person
Kaumātua	Male elder
Kaupapa	Agenda
Kōhanga Reo	Māori language nest
Kuia	Female elder
LMC	Lead Maternity Carer
LTC	Long Term Conditions
Mana whenua	People who have authority over the land
Mataawaka	Māori living in the Auckland region whose ancestral links lie outside of the Tāmaki Makaurau region
MoH	Ministry of Health

MOU	Memorandum of Understanding
NCSP	National Cervical Screening Programme
NIR	National Immunisation Register
NRA	Northern Region Alliance (North and Northern Region DHB support Agency)
NSH	North Shore Hospital
OIS	Outreach Immunisation Service
ORL	Otorhinolaryngology (ear, nose, and throat)
Pai ora	Healthy futures
PAM	Potentially Avoidable Hospital Admissions
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care
Q1, Q2, Q3, Q4	Quarters 1–4, i.e. by 30 September, 31 December, 31 March or 30 June
QALY	Quality-adjusted life years
RACIP	Residential Aged Care Integration Programme
Rangatahi	Youth
RFP	Request for Proposal
SIA	Services To Improve Access
SME	Self Management Education
Tāngata Whai i te Ora	People seeking wellness, mental health service users
Tamariki ora	Child services
Te Pou Matakana	North Island Whānau Ora Commissioning Agency
Te Runanga o Ngāti Whātua	Ngāti Whātua Tribal Council
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention
WCTO	Well Child/Tamariki Ora
Whānau	Extended family
Whānau hui	Meeting with extended family or family group
Whānau Ora	Families supported to achieve their maximum health and wellbeing
WTK	Waitakere Hospital
YTD	Year-to-date