Auckland DHB

Annual Plan

2012/2013

29 June 2012

Te Runanga  Ngati Whatua

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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

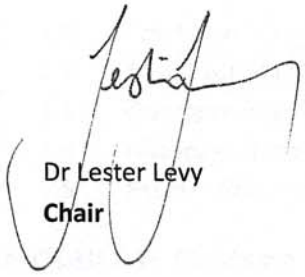
"Kaua e mahue tetahi ki waho
Te Tihi Oranga O Ngati Whatua"

Te Runanga o Ngati Whatua

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

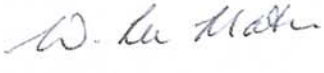
The Auckland District Health Board Annual Plan for 2012–13 is signed for and on behalf of:

Auckland District Health Board



Dr Lester Levy
Chair

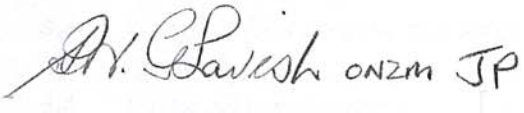
Date
11th June 2012



Dr Lee Mathias
Deputy Chair

Date
12th June 12

Our Te Tiriti of Waitangi partners
Te Runanga o Ngati Whatua



7th June 2012

R Naida Glavish JP
Chair, Te Runanga o Ngati Whatua

Date

And signed on behalf of

The Crown

Hon Tony Ryall
Minister of Health

Date

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

16 JUL 2012

Dr Lester Levy
Chair
Auckland District Health Board
PO Box 92 189
Greenlane
AUCKLAND 1142

Dear Dr Levy

Auckland District Health Board 2012/13 Annual Plan

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

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

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

Health targets

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

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

Shorter waiting times

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

Integrated care

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

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

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

Living within our means

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

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

I am pleased to see that your DHB is planning to break even for the next three years. I will be watching your management of financial performance with keen interest during 2012/13, given the level of improvement initiatives and savings target supporting your planned net results. I also expect that any savings identified will not impact your DHBs performance in service delivery, particularly across cardiac services.

Savings from the community pharmaceutical budget

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

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

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

Health of older people

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

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

Regional Integration

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

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

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

Whānau Ora

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

Mental Health Ringfence

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

Prime Ministers Youth Mental Health Project

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

Cardiac Services

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

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

Diabetes Care

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

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

Community Pharmacy Services Agreement

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

Annual Plan Approval

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

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

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

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

Yours sincerely

Hon Tony Ryall
Minister of Health

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Te Tiriti o Waitangi Statement

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

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

Co-operative rangatiratanga and kawanatanga

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

Whanau Ora

Auckland DHB, and its manawhenua partner Ngāti Whatua, will work to implement a whānau ora approach across Auckland DHB health services. This will be achieved by:

- Working across sectors and with multiple agencies to create integrated pathways of care that promote improved health outcomes for whānau and reduce health inequities; and
- Empowering whānau through their involvement at all levels of decision making, and the provision of personalised packages of care that meet their needs.

Principles in action

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

MODULE 1: Introduction

1.1 Foreword from Chair and joint Chief Executive

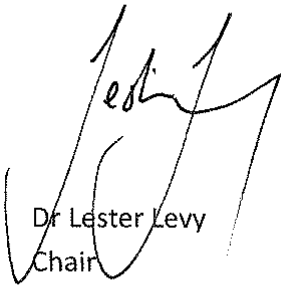
The compelling and overriding theme for 2012/13 is further improvement in our delivery of health services to our patients and population. The Government's key requirement of Auckland DHB in the next financial year is to deliver better, sooner, more convenient care, and to lift health outcomes for patients – within constrained funding. Whilst we all understand the international and local financial and economic environments, the good news is that the Government is continuing to increase its investment in public health, but within a tighter financial framework. We will need to be highly disciplined in order to lift our productivity, but we will need very strong clinical leadership. Capital expenditure will be particularly constrained for 2012/13, requiring us to carefully prioritise expenditure and to create more opportunities to fund capital from our own resources.
Our key priorities for the 2012/13 year link directly to the Minister of Health's letter of expectations:

- *Improve population health by:*
    - Achieving the Health Targets, especially waiting times – while further shortening of waiting times for elective surgery, diagnostics and cancer care is very positive for patients, it will require innovation and new models of care to be introduced into Auckland DHB. Our regional cancer service team is preparing with determination to meet the new cancer waiting time target, which will see patients receiving chemotherapy within four weeks of a decision to treat - this year we will reallocate resources as we move from 95% of this target to 100%
    - Improving service integration - we will focus on service integration, particularly with primary care, and we will do this more quickly. Particular attention will be on developing integrated family health services, getting patients referred to diagnostic and clinical pathways that involve both community and hospital clinicians. Also wrap-around services for older people that support their continued safe, independent living at home. We will also boost our regional after-hours programme by ensuring that there are no fees for after-hours doctor visits for children under 6 years of age
- *Improve patient safety and experience* – further developing a culture of clinical excellence coupled with service to our patients. Enhancement of the patient experience will be undertaken in a complementary manner with the local patient safety and quality initiatives from the regional 'First do no harm' programme. We will also be encouraging our senior clinicians and managers in new ways of working which create a momentum for change, and an environment where staff are responsive, transparent and innovative – with a bias for action. A particular emphasis will be placed on the health of older people for whom we will develop existing services that support sustainable, safe, and independent living at home. A dedicated stroke unit is already in place and

showing real benefits and the development of a comprehensive care pathway for older people with dementia is a priority.

- *Improved sustainability* – we will achieve a break-even financial position in 2012/13 which will require heightened effort to improve processes, implement service improvements and reduce waste through new models of care, in-sourcing of services and acceleration of our regional work with the other northern region DHBs, but particularly with Waitemata DHB. The two DHBs plan to build on current collaborative activity in 2012/13 to enhance health outcomes and improve the quality of service delivery for their populations while capitalising on efficiencies through economies of scale, scope and critical mass.

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



Dr Lester Levy
Chair
Auckland DHB

Dr Margaret Wilsher
Joint interim Chief Executive
Auckland DHB

Ngaire Buchanan
Joint interim Chief Executive
Auckland DHB

1.2 About Auckland DHB

Eighty seven percent of the Auckland DHB population live within five wards within the Auckland DHB boundary. The other 13% live in either the Manukau ward within the Counties Manukau DHB area, or the Whau ward within Waitemata DHB.

Snapshot of Auckland DHB

- Auckland DHB has over 468,000 people with a projected growth of 19% or 86,000 more people by 2026
- We are a diverse population: 52% Pakeha, 29% Asian, 11% Pacific, 8% Mäori and 2% Other
- We are relatively young: 10% of the people domiciled in the Auckland DHB district are aged 65 years and over, compared with 12% of NZ population. 17% are aged under 15 years, compared with 22% for all of NZ
- Māori people are estimated to number 36,300 or 7.9% of the total Auckland DHB population
- Pacific people are estimated to number 51,890 or 11.2% of the total Auckland DHB population. This group is characterised by a great diversity of culture, ethnicity and language
- Asian people make up 29% of Auckland's population. 36% of these are South Asian, and about 80% of this group are Indian
- Auckland has one of the highest non-English, non- Māori speaking areas with over 100 different languages spoken
- 39% of our population lives in areas with a New Zealand deprivation index of less than seven (10 is the most deprived)
- In the 2006 census, Maungakiekie-Tamaki was the most deprived ward in our Auckland DHB with 67% of people living in an area more than 6 on the NZ deprivation index
- The least deprived ward is Orakei with 8% of this population living in an area with a scale of more than 6
- Over a third of our children (38% of all 0–14 year olds) live in the most deprived areas of the city (NZDep 9 and 10). Of that 38 percent, 72% are Pacific, 49% are Mäori and 21% are 'Others'
- 13% of our population need assistance or interpreting when attending health services
- Cancer and heart disease remain the biggest health problem areas for our district

1.3 Our Operating Environment: What we do

Auckland DHB is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004) and must conform to the requirement of this Act and others such as the Public Finance Act, 1989. Other legislation also impacts on our operations such as the State Services Commissioner's Standards of Integrity and Conduct.

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

This annual plan addresses local, regional and national needs for health services, how health services can be properly coordinated to meet those needs and the optimum arrangement for the most effective and efficient delivery of health services, within the funding available.

The Statement of Intent, which forms part of this document (Modules 1, 2, 4, 5 and 7) is also an accountability document. It is used at the end of the year by auditors to compare the DHB's planned performance with actual performance as reported in our Annual Report.

1.4 Nature and scope of Auckland DHB

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

Governance

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

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

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

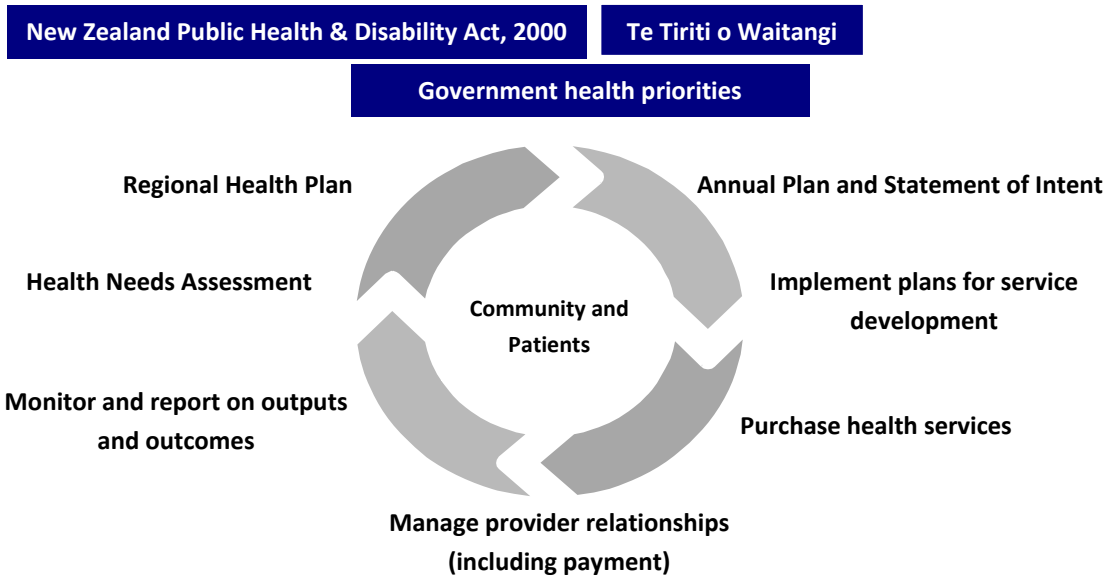
In 2011, Auckland DHB's Community and Public Health Advisory Committee (CPHAC) and Disability Advisory Committee moved to hold joint meetings with their equivalent advisory committees of the Waitemata DHB. The Auckland and Waitemata DHBs also have a joined non-statutory Māori Health Gain Advisory Committee: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

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

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

Planner

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



In 2012-13 we will integrate more services across the continuum of care, especially moving services into community settings where this improves access for patients and is efficient.

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

Funder

The total value of services for the Auckland DHB population is approximately one billion dollars. We received a total increase of $32m in the 2012-13 Funding Envelope, as population based funding. The increase is for a contribution to cost growth pressure of $15.2m and a contribution to demographic demand growth of $17m.

Auckland DHB also provides services for people who live in other DHB areas; the value of this work is approximately $668 million for which we receive payment from other DHBs. Auckland DHB also pays about $100m for services that our Auckland residents receive in other DHBs. In total, the annual turnover from our population funding and from work we do for others is approximately $1.6 billion.

During 2012-13 we will be responsible for the funding of services purchased from non-DHB providers to a total value of $582m for Auckland residents, and $215m for people who live in other DHB areas.

Planning and funding staff work with Healthcare Service Groups within the provider arm to make sure the allocation of funding meets our population's health needs and that our patients receive Better, Sooner, More Convenient services.

While some community services are provided through our provider arm (A+ Links Home Health Care, Rehab Plus, community mental health services, community child health and disability services), we also contract with Non Government Organisations (NGOs) to provide health and disability support services for people living in the Auckland DHB area.

Some services are covered by a regional contract and therefore cover people living across the wider Auckland region e.g. some general practice work, and supported accommodation for people with severe mental illness. Laboratories, Community Pharmacies, and Health of Older People are also funded by the Auckland DHB.

The funder also has alliance arrangements with three primary care partners in order to develop primary healthcare:

- Greater Auckland Integrated Health Network (GAIHN) covers over one million enrolled people across 4 PHOs within the greater Auckland region
- Alliance Health+ is a Pacific-led PHO working across Counties Manukau DHB and Auckland DHB
- National Hauora Coalition is a North Island consortium of PHOs focused on Whanau Ora and high needs populations

Provider

Auckland District Health Board is a major provider of health care services to people domiciled in the district, and to people from elsewhere. The Auckland DHB 'provider arm' includes Auckland City Hospital, the Greenlane Clinical Centre and a number of community-based services, which include: Rehab Plus, A+ links home healthcare, community mental health services, community child health and disability services.

Snapshot of our provider arm

- Auckland City Hospital is New Zealand's largest public hospital as well as the largest clinical research facility. There are approximately one million patient contacts each year, including local hospital and outpatient services
- We have three major facilities: Auckland City Hospital (Grafton) which is New Zealand's largest public hospital, Greenlane Clinical Centre (Greenlane) and the Buchanan Rehabilitation Centre (Pt Chevalier)
- We have approximately 10,000 staff employed in the provider arm which equates to a little over 8,000 full-time equivalent positions (FTE)
- Auckland DHB is also the largest trainer of doctors in the country with approximately 1,477 medical staff of whom about 685 are in various stages of training.
- Over half the work done within Auckland DHB hospitals is for people who live outside Auckland city
- Each year we have approximately 150,000 inpatient events, 100,000 First Specialist Assessments, and 250,000 Follow-Up contacts
- The hospital has the largest elective surgery delivery system in New Zealand with 22,000 elective discharges, approximately 52% of which are for other DHB populations
- Some tertiary services (e.g. clinical genetics and paediatric oncology) are provided for people in the Northern, Midland and Central regions. Some of the specialist services provided for the whole of New Zealand include (not an exhaustive list):
    - organ transplant (heart, lung and liver)
    - acute major airway obstruction transferred for laser or stent placement
    - massive haemoptysis transferred for surgery or bronchial arterial embolisation
    - hepatic laceration requiring acute hepatic surgery
    - specialist paediatric services
    - epilepsy surgery
    - deep brain stimulation
    - high-risk obstetrics

Auckland Regional Public Health Services

The Auckland Regional Public Health Service (ARPHS) is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB under

a contract with the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. Auckland Regional Public Health Services ensure quick and effective responses to outbreaks, environmental hazards and other emergencies, which in turn reduces downstream expenditure on the consequences of uncontrolled health threats.

Other public health services, e.g. health promotion and healthy public policy, also help to reduce demands for personal health services though influencing medium and long-term health outcomes.

Owner of Crown Assets

Auckland DHB is wholly owned by the Crown. Auckland DHB must operate in a fiscally responsible manner and be accountable for the Crown assets we own and manage. We are required to demonstrate strong governance and accountability, risk management, audit, performance monitoring and reporting. To this end, we undertake formal asset management planning to determine planned future asset replacement and expected financing arrangements.

We also revalue property, plant and equipment in accordance with NZ International Accounting Standard 16 with our land and buildings re-valued every three years. The last revaluation occurred in 2011 on an "Optimised Depreciated Replacement Costs" basis.

Other interests

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB.

Auckland DHB is a shareholder in a number of Crown entity subsidiaries namely Northern DHB Support Agency Limited, Northern Regional Training Hub Limited, New Zealand Health Innovation Hub Management Limited, and healthAlliance N.Z. Limited. Canterbury, Counties Manukau, Waitemata and Auckland DHB are limited partners in the New Zealand Health Innovation Hub.

Auckland DHB has no plans to acquire shares or interests in any other company, trusts and/or partnerships.

1.5 Factors Affecting our Performance

Our Northern Region Health Plan has five drivers for change:

1. the need to improve population health outcomes and reduce disparities
2. manage growth
3. respond to financial pressures
4. deliver Better, Sooner, More Convenient services, and
5. improve quality and patient safety.

Our challenge is to offer, and in some cases grow, quality health services where health spending is forecast to grow much more slowly than previously. Also we know that in future there will be fewer people of working age, and the number of retired people compared to those of working age will double. Achieving the best health outcomes from the available resources requires a focus on:

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

Key areas of risk and opportunity

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

MODULE 2: Strategic Direction

2.1 Auckland DHB priorities

Our vision is of a healthy local population, and quality health service across the continuum when people need it – *Healthy Communities, Quality Healthcare ~ Hei Oranga Tika mo te iti me te Rahi*

Our mission – *Deliver the right care, at the right time, in the right way*

Three goals focus our decisions and actions:

1. Lift the health of people in the Auckland DHB area
2. Lead performance improvement
3. Live within our means

Organisational values:
Integrity, Respect, Innovation, Effectiveness
– Kia u ki te tika me te pono

These goals align with the triple aim in the Northern Region Health Service Plan. They help us focus on distinct streams of work, all important in meeting our statutory and government policy responsibilities. Performance measures help us track progress in each area so that we know where we are making a difference and where we need to improve.

Auckland DHB Board Priorities for 2012-13

Critical issues will be resolved by 30 June 2012. Some activity focuses on internal systems and processes (Inter-District flows, Funder profile of demand management, Risk Assessment Framework, and Information Technology business continuity assurance). Other activity has a direct impact on patients:

- future development of Starship Children's Health
- patient access to elective surgery
- improvements to our mental health services including alcohol and drug services

Strategic priorities

- achieve greater productivity over time
- change in the culture of the organisation
- change in how we deliver care i.e. integration of services
- alleviate some of the demands on specialist hospital services
- more DHB collaboration within and across the region

Operational Priorities. These focus on the targets we must reach by July 2013

- Emergency Care – 6 hour target at 95%
- Shorter waiting times for cancer treatment - radiation and medical oncology within four weeks
- Health of Older People – integrated service
- Enhanced safety and quality
- No financial deficits
- Māori Health priorities

Māori health is a significant priority for the Board and our Memorandum of Understanding partners: Te Runanga o Ngati Whatua. Priorities that address the health of Māori who live within, and those who access our services from outside of, our boundaries feature throughout our plan, notably around whānau ora and areas where inequity in health outcomes exist between Māori and non-Māori. These are included in our Māori Health Action Plan 2012-13 which directly aligns to targets and priority areas within this plan.

2.2 The National Setting

Better, Sooner, More Convenient Services

The overarching goal for the health sector is Better, Sooner and More Convenient health services for all New Zealanders (BSMC services). The principles underpinning this are:

- a partnership approach to service planning involving primary care and secondary care clinicians and managers
- a whole of system view to determine the most efficient model of service delivery
- some traditionally 'hospital-based' services are delivered in community/primary care settings
- engaging 'front-line' clinical leaders in health services delivery planning
- integrating/coordinating clinical services so there is greater accessibility and seamless delivery
- strengthening clinical and financial sustainability
- making better use of available resources

National Health Sector Priorities

The Minister's Letter of Expectations for 2012-13

Deliver better, sooner, more convenient care

Lift health outcomes for patients within constrained funding increases

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

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

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

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

- Unplanned and urgent care
- Long-term conditions
- Zero-fees after hours GP visits for children under 6

- The Prime Minister's Youth Mental Health Project

Shorter waiting times in key areas: Surgery, Diagnostics, Cancer care, Dedicated stroke units and Dementia

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

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

National Health Targets focus DHBs on achieving rapid progress in key areas. Auckland DHB is committed to achieving and exceeding the health targets. Our DHB has made significant progress towards achieving the targets but we still have further improvements to make in 2012-13. Those activities specifically focused on the health targets are covered in module 3.

National Health Targets for 2012-13

Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Nationally, the volume of elective surgery will be increased by at least 4,000 discharges per year. Auckland DHB will deliver 12,891 elective volumes during 2012-13
Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within four weeks
Increased immunisation	85% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90% by July 2014, and 95% by December 2014
Better help for smokers to quit	95% of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking Progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit
More heart and diabetes checks	90% of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75% by 1 July 2013, and DHBs exceeding 75% are expected to be actively moving toward the 90% goal

The larger suite of national performance measures for DHBs is covered in Appendix 1. DHB activities to deliver government expectations are detailed in Module 3.

National Service Improvement Programmes

Work to develop National Services and National Service Improvement programmes is underway with the aim of improving equity of access, quality, consistency and sustainability for vulnerable services. This work particularly relates to high cost, low volume specialist services e.g. paediatric, and

congenital cardiac services. Lead DHB providers are responsible for providing and developing a national service, most of which is funded from "top slice".

DHBs that are recipients of the service are expected to work with the national service provider, supporting outreach clinic arrangements that improve access for their populations. National Service Improvement programmes require the commitment of clinicians and managers within DHBs.

2.3 Regional Commitments

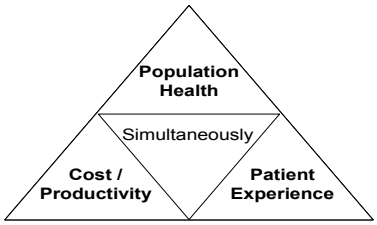
The Northern Region Health Plan

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

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

Our Mission:

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



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

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

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

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

Auckland DHB's activity for the 2012-13 year aligns to the Regional Plan as shown by the planning framework diagram on pages 18 and 19. Our contribution to the Northern Region Health Plan includes:

- Chairing the Steering Group
- Clinical Sponsorship of the overall programme
- Clinical Sponsorship of the Cancer and Informed Patient Choices (Advance Care Planning) workstreams
- Membership of all of the 'Big Dot' Campaigns; Regional Clinical Leaders' Forum; Regional Chairs / Chief Executives Forum; and Northern Region Health Plan Steering Group

Three regional goals in addition to achieving national targets

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

Shorter term actions are reflected in module three this annual plan. Further detail about our Region Health Plan and deliverables for the 2012-13 year is contained in this link: http://www.ndsa.co.nz/LinkClick.aspx?fileticket=9jPfQglLjkk%3d&tabid=100

Arrangements across DHB Boundaries

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

The two DHBs share a Board Chair and now have sub-committees that meet jointly. More areas of DHB activity will be joined, especially where collaboration will improve health outcomes and service delivery. The merge of the primary care Planning and Funding Teams has already increased consistency of relationships and primary care management across the two DHBs. Any joining of activities across DHB boundaries will be carefully managed so that neither DHB is disadvantaged as a result of changes.

Areas of collaboration across Auckland and Waitemata DHBs

Māori Health	Auckland and Waitemata DHBs will do more to integrate Māori Health services. A Chief Advisor Tikanga sits across both DHBs with the endorsement of Te Runanga o Ngati Whatua. The benefits of this joined arrangement include: • direct relationship with Iwi and an Iwi endorsed position (i.e. is a joint appointment between Te Runanga O Ngati Whatua, Auckland DHB and Waitemata DHB) • consistency of Ngati Whatua Tika across the DHBs • a consistent Whanau Ora strategy • a single point of reference for Tikanga to reduce fragmentation of Tikanga policies and practices, and to allow direct access to Tikanga advice for DHB Board members, CEOs and staff • improved cultural competency for all DHB staff • demonstration of DHB leadership in responding to Iwi partnerships. A model of future operation will be developed in 2012-13, involving managers from both DHBs and our iwi partner, Te Runanga o Ngati Whatua. Any changes proposed as a result of this and approaches to the two Māori Health teams will be consulted on. Auckland DHB is committed to its Memorandum of Understanding with Te Runanga o Ngati Whatua, and all Māori who reside, or chose to access health services, within our district. Given that Ngati Whatua are accountable to Māori across both Auckland and Waitemata DHB boundaries, a joint Māori health strategy will be developed to not only support Ngati Whatua aspirations, but also achieve greater Māori health gain. This will establish the regional strategic Māori health vision and approach for the next 3 – 5 years and demonstrate a commitment to iwi and Māori within our region. The strategy will build on the first joint Māori Health Action Plan which details DHB activity in the 2011-12 financial year.
Pacific Health	Collaboration of Pacific Health services between Auckland and Waitemata DHBs will help to deliver high quality services and outcomes to our Pacific populations. We will develop new ways of working in 2012-13 that make the best use of resources

	across the two DHBs. The optimal arrangement will be identified after considering the strengths of our respective approaches and consultation feedback from staff, key stakeholders and other interested parties.
Primary Healthcare	Delivering better, sooner, more convenient services requires integrating services – specifically primary care with hospital services. Auckland DHB's Integrated Health Service Groups were established in 2011 to ensure that healthcare is integrated across primary and secondary care. Clinical Directors are now responsible for ensuring that work in their healthcare area (cancer, cardiology, mental health, adult health, and women's health) are well integrated across the whole spectrum of healthcare i.e. community based and hospital based. We will increase the scope of work and speed the development of care in 3 areas: • unplanned and urgent care • long-term conditions • wrap-around services for older people. Activity to deliver better, sooner, more convenient service is detailed in module 3.
Mental Health	Shared General Manager of Mental Health and Addiction services across both DHBs.

Planning Framework: Priorities, key impacts and performance measures

The table shows the alignment of local priorities to regional and national priorities.

Government policy	**Better, sooner, more convenient health services** Regional collaboration Integrated care Value for money		
Regional mission	Improve health outcomes and reduce disparities through better, sooner, more convenient services Meet future demand while living within our means		
Regional triple aim objectives	**Population Health** Adding to and increasing the productive life of people in the northern region, areas of focus: Diabetes, Cancer, CVD, Child Health, Older People, Respiratory Disease, Mental Health & Addiction	**Patient Experience** Zero patient harm, and performance improvement – regional governance & leadership – Respond to vulnerable services ('sustainability')	**Cost/Productivity** Regional resources well managed – Progress regional Capital, IT and Workforce priorities
National health sector targets	Immunisation Tobacco	Emergency Departments Access to Elective Surgery Cancer Services CVD / Diabetes	Living within our means
ADHB Board priorities **2012-13**	Meet or exceed these National Health targets: – Immunisation – Tobacco Māori Health priorities – National priorities – Regional priorities – District priorities Partnership with Te Runanga o Ngāti Whatua Mental Health – proactive approach to drug and alcohol problems	Meet or exceed these National Health targets: – Elective Surgery – Emergency Departments – Cancer Services – CVD / Diabetes Starship and Children's Health Integration (patient journey) – Whanau Ora – Primary Care – Health of Older People – General Practice and PHO – Locality structures – Transferring patient care Enhanced safety and quality Organisational Culture – Clinical engagement – Innovation: new models of care	Meet or exceed every National Health target: Living within our means Funder to develop a profile of demand management Inter-district flows Vulnerable services Risk Assessment Framework Information technology business continuity assurance Integration (patient journey) – Productivity & value for money Organisational Culture – management and leadership capacity – strategic human resource Productivity Allocative efficiency Regional collaboration No financial deficits
Auckland DHB three goals	Lift the health of people living in the ADHB area	Performance improvement	Live within our means
ADHB Key Result Areas	Improved health status	Increased patient safety Better quality care Staff engagement	Economic sustainability
Local vision	Healthy communities, quality healthcare – *Hei Oranga Tika, mo te iti me te Rahi*		

DHB measures of performance

National health targets	Increased immunisation	85% of 8mth olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time by July 2013
	Better help for smokers to quit	95% of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking Progress towards 90% of pregnant women are smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit
	Shorter stays in ED	95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours
	Improved access to elective surgery	At least 4,000 additional discharges (nationally) per year
	Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within 4 weeks
	More heart and diabetes checks	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years. Achieve at least 75% by 1 July 2013

National measures of performance	Workforce – Improving clinical leadership	Children caries-free at 5 years of age
	Implementation of Better, Sooner, More Convenient Health Services	Use of DHB-funded dental services by adolescents from School Yr 9 up to 17 years
	Improving the health status of people with severe mental illness through improved access	Improving the number of children enrolled in DHB funded dental services
	Improving Mental Health services by relapse prevention planning	Workforce – improving career planning
	Shorter waits (non-urgent) mental health and addiction services	Improving community support to maintain the independence of older people
	Oral Health- Mean DMFT score at Year 8	Improved management for Long Term Conditions (CVD, diabetes, stroke)
	Ambulatory sensitive (avoidable) hospital admissions	Standardised Intervention Rates
	Delivery of Regional Service Plans	Delivery of Whānau Ora
	Ensuring delivery of Service Coverage	Improving breastfeeding rates
	Inpatient Length of Stay	Elective & Arranged Day of Surgery Admission
	Theatre Utilisation	Reducing Acute Readmissions to Hospital
	Elective and Arranged Day Surgery	Improving Quality of Data submitted to National Collections
	Output Delivery Against Plan	Faster cancer treatment
Regional measures	These align to national and local measures, i.e. great degree of overlap here. Detailed in appendix one.	

Output measures *Cornerstone measures that cover business as usual*	Output class 1: Prevention	Health Promotion, Policy, legislation, advocacy, advice Health Protection, Population Based Screening
	Output class 2: early detection & management	Community Testing & Diagnostics Oral Health, Primary Health Care, Pharmacy
	Output class 3: Intensive assessment & treatment	Acute Services, Maternity, Elective (Inpatient/Outpatient) Assessment, Treatment and Rehabilitation, Mental Health
	Output class 4: Rehab Support	Home Based Support, Palliative Care, Residential Care

2.4 Risks and opportunities

The risks and opportunities we identify relate to Auckland DHB's goals and hence the implementation of this Annual Plan. This list does not cover all the risks we are exposed to in the normal management of District Health Board business; a full register of risks exists and is regularly updated. Our Board also maintains a risk assessment schedule.

Issues and risks impacting on achievement of our goals

Issues and risks	Mitigation strategies
Some business cases included in this plan have not been through the full approval process	All final business cases will be confirmed prior to the start of the financial year. All external contracts for discretionary health services, funded directly by Auckland DHB (including our own hospital and related services) will be reviewed in 2012-13. The review will investigate whether contracts are producing the best value for money (effectiveness, equity, efficiency and whanau ora). We will assess if the funding can be better allocated or if there is some way to achieve health gain more effectively. Providers will be kept up to date with this contract review process and any substantial service changes likely will be subject to consultation requirements and good contracting processes, including sufficient notice being given of any changes. The process will comply with the requirements of the Operational Policy Framework
Adult and Paediatric surgical capacity to respond to both the needs of Auckland DHB-domiciled patients and patients referred to us from outside the district	Aligning capacity, volume requirements and budget allocation to ensure plans achievable
The adult Emergency Department's capacity to respond to growth from aged residential care	See module 3, section 1
Some services are identified as vulnerable through the regional health planning process: – Head and neck (complex high needs service) – Neonatal services (number of cots too low for region) – Bone marrow transplant service (workforce and physical capacity) – Maxillofacial surgery (workforce) – Diabetes because of its growth and the workforce constraints – Older Peoples Health because of the same	Vulnerable services are being progressed through the Regional Health Plan A work programme is also underway to develop National Services and National Service Improvement programmes. This will improve equity of access, quality, consistency and sustainability for vulnerable services, particularly those high cost, low volume specialist services, e.g. paediatric and congenital cardiac services. Lead DHB providers are responsible for the provision and development of national services, most of which are funded from "top slice".

Issues and risks	Mitigation strategies
The demand for some health services in our region is growing at a rate significantly higher than the growth of our population. This particularly affects demand for Emergency Departments, acute medicine and surgical services, radiology, cancer and cardiology. The services under the greatest pressure are those providing care for people with chronic diseases and those services for the elderly: home based support services and residential care.	Long term clinical service planning is focused on clinical and financial sustainability. Repatriation of specific services between DHBs is ongoing to support better local access to care and relieve demand. Our regional capacity to deliver services is strongly influenced by the historic location of facilities and diagnostic support services, together with historic patterns of workforce availability.
Ability to respond fast enough to cost pressures and to lift productivity quickly enough to match demand growth	Clear intervention initiatives and close management
Lead time(s) to develop appropriate capacity may delay delivery	Service and pipeline capacity planning
Acute presentations at different levels than estimated in the plan	Trade-off analysis and management with other services
High growth in demand due to legislative entitlement and demographic growth (Aged Residential Care); and similarly health gain initiatives and extra funding for drug use by Government policy will increase Auckland DHB spend on pharmaceuticals. The draft budget assumes a $1m reduction in dispensing fees.	Aged Residential Care – continue with Home-based support services development to relieve pressure on rest homes Pharmaceuticals – participate in national DHB/Pharmac initiative to implement new national contract for dispensing.
NGO sector may have differing expectations of recognition by Auckland DHB of cost and demand growth	Current draft budget for 2012-13 has Contribution to Cost Pressure and, as appropriate, demographic growth allocated.
The impact of the primary care business cases and any subsequent devolution has yet to emerge	Work closely with the primary care business case groups to identify and develop appropriate budget requirements
That the planned $1m recovery from funding fraud actions is not achieved	Strong investigative and legal actions
Budgets are based on assumptions and predictions of future activity. This carries a risk that future events are not in accordance with these predictions	Processes for monitoring variations so that actions can be identified to address any variation. Close monitoring of volumes
Budgeted to achieve a break even position within the allocated funding and to manage the various environmental factors that impact on budget That the current level of funding available to Auckland DHB proves insufficient for the scope and scale of services that are demanded over the year. This includes the risk of new unfunded initiatives since development of the annual plan	Reprioritise and reallocate resources and carry out initiatives in clinical resource use and practice changes, productivity improvements, reduced administrative costs and procurement savings Close management of cost of service and support of productivity improvement and cost containment strategies within available resources

MODULE 3: Delivery of Priorities and Targets

This Annual Plan is a component part of, and aligns to, wider regional activity but its focus is key activities for Auckland DHB. The focus is on actions that achieve national health targets, priorities in the Minister's Letter of Expectations and the Auckland DHB Board–approved priorities. These are areas of new or amplified activity as opposed to our business as usual. Initiatives included in this module three have been approved and budgeted. Module five includes some business-as-usual activity within our statement of forecast service performance.

Our priority actions and targets for 2012-13 align to the region's three priority (outcome) areas for 2012-13.

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

Health targets

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

Improved service integration

- Cardiac Services
- Service integration: Primary care development and delivery
- Community and Outpatient Access to MRI and CT Imaging
- Mental Health and Addictions
- Health of Older People
- Whānau Ora
- Child Health
- Youth Health
- Pacific Health
- Women's Health

Living Within Our Means

We also include other Auckland DHB priorities

- Diversity and reducing inequities
- Disability
- Clinical/Change Leadership
- Workforce
- Patient and Family / Whanau Experience

3.1 Emergency Departments

This is important for community and patients

Work in this area means people spend less time waiting for and receiving emergency department treatment. Reduced waiting times for treatment means better outcomes and improved quality of health services. By improving our performance in both adult and child Emergency Departments we also improve hospital productivity because we achieve better patient flow and more efficient use of resources. By working across the system, people living in residential care avoid unnecessary admission to hospital and are treated in their facility wherever possible. Our activity in this area will support the achievement of our regional targets for Emergency Departments.

How are we going to do this?

The patients' length of stay is right for their care

- Develop and implement hospital triggers and escalation response to waiting times within the Emergency Department and access block including standardised responses
- Review the medical assessment of patients presenting to the Emergency Department to avoid duplication of effort between Emergency Department and inpatient specialities
- Develop and implement bed forecasting model to improve seasonal planning
- Reduce acute presentations to the Adult Emergency Department through supporting GAIHN's work programme of targeting patients at high risk of acute hospitalisation through predicative risk analysis
- Support the GAIHN approach to management of acute events in residential care (both in and out of hours)
- Support GAIHN's alternative pathway for status 3 and 4 St John transported patients to reduce number of presentations to Emergency Departments for those patients who could be safely managed in a primary care setting
- Support GAIHN's implementation of integrated care for high risk individuals identified by the GAIHN Predictive Risk Algorithm

Children's Emergency Department

- Create a programme that helps us predict hospital occupancy -7 days out – and 24 hour review
- Review all 6 hour breaches to identify causes of the breach and to implement actions to reduce risk of breaches occurring
- Support GAIHN's project to reduce avoidable hospitalisations for key childhood illnesses of: child gastroenteritis, bronchiolitis, asthma and cellulitis (scoping 2012/13, impact 2013/14)
- Support the National Hauora Coalition's Mama, Pepi, Tamariki programme to reduce ASH rates for under 2 year olds, in particular relation to respiratory conditions

Specific deliverables and measures

- 95% of all patients (adults and children) will be admitted, discharged or transferred within 6 hrs
- 100% of adult patients will be transferred to an inpatient bed within one hour of bed request
- 100% of children will be transferred to an inpatient bed within one hour of bed allocation
- Combined single patient assessment document for Emergency Department and inpatient specialties in place
- 10% reduction in number of residents from aged care facilities presenting to Adult Emergency Department from (from 6,205 presentations to 5,585]
- Auckland DHB will access and track readmission rates for people over 65 years of age
- Occupancy predictions for child Emergency Department are accurate to +/- 5 percent
- Support National Hauora Coalition's reduction for ASH rates for under 2 year olds by 1% from baseline
- 20% decrease in bed days for high risk individuals identified by the GAIHN Predictive Risk Algorithm (3151 patients identified for Auckland DHB)
- 2,000 bed day reduction in Acute admissions from aged care sector across the northern region
- 20% of all status 3 and 4 patients transferred by St John to a primary care setting instead of to Emergency Department (this is 30 patients a day: approximately 20% of all) – 11,000 patients a year across the metro region

3.2 Improved Access to Elective Surgery

This is important for community and patients

Improving people's access to elective surgery starts with patients getting fast access to diagnostics and specialist assessment. We want patients to get the elective surgery they need without having unnecessary waits on booking lists. Patients needing specialist assessment and elective surgery will get this more quickly and through fairer and more transparent decision making. Our activities for 2012-13 focus on surgical throughput and wait times. These activities will help us to achieve our regional targets for Elective surgical discharges.

How are we going to do this?

We will deliver elective surgical volumes that:

- Improve the intervention rates for the Auckland DHB population
- Support our Inter District Flow DHBs
- Reduce wait times

The DHB will implement four project streams, three of which will redesign patient electives pathways and one will design elective resource management tools and processes over short, medium and long term time horizons. The four project streams are:

- The Orthopaedic patient pathway
- The Otorhinolaryngology (ORL) patient pathway
- The Ophthalmology patient pathway
- A resource management project, to support the three pathway projects and other electives pathway and process efficiencies

Specific deliverables and measures

- Deliver 12,891 elective surgical discharges for the Auckland DHB population
- Joint, cataract and cardiac intervention rates required are met
- Comply with the wait time standard of no patients waiting longer than 5 months from referral to First Specialist Assessment (FSA)
- Comply with the wait time standard of no patients waiting longer than 5 months from First Specialist Assessment to surgical procedure
- Completion of the integration of new referral, screening and follow up protocols for the Orthopaedic patient pathway
- Completion of the implementation of revised follow up clinic management procedures and their incorporation, for the Otorhinolaryngology (ORL) patient pathway
- Implementation of revised elective surgical pathways for the Ophthalmology patient pathway

- Commencement of roll out of medium term planning procedures for the resource management project
- Theatre utilisation target of 85% (OS5)
- Rates of day of surgery target of 60% (OS6)
- Rates of day of surgery admission (DOSA) target of 68% (OS7)

3.3 Cancer Services

This is important for community and patients

In 2012-13 we are focussing our effort on achieving shorter waits for cancer treatments. In doing so, we will sustain our performance against the radiation therapy target. As of 1 July 2012 we will deliver to the newly introduced chemotherapy wait time targets.

In preparation the introduction of the 62 day performance measure, significant work is required to improve waiting times across the entire patient journey. This requires the development of a reliable system to monitor the speed with which patients suspected of cancer are diagnosed and treated.

Colonoscopy waiting times are a major concern for Auckland District Health Board. We will therefore meet the new Ministry of Health indicators for colonoscopy. We will improve the patient experience through better care coordination, particularly for Māori and Pacific patients. Two other goals for the coming year for this DHB are to increase our cervical screening coverage for Māori, Pacific and Asian women, and to increase access to bone marrow transplantation for patients with haematological malignancies.

The Northern Region Health Plan contains actions that will improve patient access to diagnostic and cancer treatment services. The Auckland DHB activities below will help us to achieve our regional targets for cancer services.

How are we going to do this?

Faster Cancer Treatment

- Maintain current radiation therapy target through consistent improvement and monitoring of in house radiation therapy capacity. Utilise ARO (Auckland Radiation Oncology) during periods of high demand
- Reprioritise capacity within the medical oncology team to ensure capacity is available to deliver to the chemotherapy target
- Implement a data collection strategy which enables reporting against the Faster Cancer Treatment time indicators

Develop capacity to deliver to national standards and improve access

- Implement the Bone Marrow Treatment business case within the regional service

Service improvement designed to produce more effective patient outcomes

- Implement agreed aspects of the Northern Region Care Coordination Model to include provision of better information and communication on receipt of referral, and on discharge

Continue to implement the tumour stream model

- Implement the regionally agreed tumour stream pathways across the Auckland DHB continuum
- Ensure tumour stream reporting requirements are met
- Work with the region to establish a reliable baseline for Surveillance colonoscopy

Multi-Disciplinary Meetings

- Increase the number of patients who are reviewed at tumour stream specific Multi-Disciplinary meetings

Develop capacity to enable data collection and submission to the repository in alignment with the model defined as the 'National view of Cancer'

- Assess capacity to develop a regional cancer data repository aligned to the above

Specific deliverables and measures

Faster Cancer Treatment

- Deliver radiation therapy to 100% of eligible patients within 4 weeks of decision to treat
- Deliver chemotherapy to 100% of eligible patients within 4 weeks of decision to treat
- We will be collecting data consistent with the Regional Implementation Plan for the Faster Cancer Treatment indicators, from 1st July.
- All patients with a diagnosis of cancer who are referred for their first non-surgical cancer treatment, to receive confirmation of this within 2 weeks of referral
- 100% of lung cancer patients/ Whanau to receive the lung cancer specific Patient Information Pathway Pack (PIPP) during 2012-13

Lung Cancer Tumour Stream (targets as agreed and documented in the Northern Region Health Plan)

- The proportion of patients referred urgently with high suspicion of cancer receive their first cancer treatment within 62 days Target 60%
- The proportion of patients referred urgently with high suspicion of cancer receive their first specialist appointment within 14 days (all treatment types) Target 50%
- The proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment within 31 days of decision to treat (all treatment types) including best supportive care Target 50%

Diagnostic colonoscopy

- 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days)
- 50% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)

Surveillance/Follow-up colonoscopy

- 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date.

Multi-Disciplinary Meetings

- Implement a single regionally agreed Multi-Disciplinary Meeting data collection form for the breast cancer tumour stream by June 2013
- Implement electronic data collection for lung and bowel cancer tumour stream for Multi Disciplinary Meetings by December 2012
- All tumour streams will have Multi-Disciplinary meetings
- We will increase the use of video conferencing in tumour stream Multi-Disciplinary Meetings
- Expand the use of electronic Multi-Disciplinary Meeting forms across other tumour types

3.4 Increased Immunisation

This is important for community and patients

By July 2013 we want to see 85% of children in the Auckland DHB area fully immunised at 8 months of age. We will improve the health and wellbeing of children in Auckland through achieving the national immunisation health target – children fully immunised at 8 months (85% in 2012/13, 90% in 2013/14, and 95% by 31st December 2014).

We will also maintain a 95% coverage rate of 2 year old children being fully immunised. This will translate into a reduction in the number of vaccine preventable diseases amongst Auckland DHB children. We'll also reduce the inequalities that exist in immunisation rates between population groups in our community in particular Māori, which will require the active participation of all stakeholders. The following activities will help us to achieve our regional target for Immunisation.

How are we going to do this?

In collaboration with primary care stakeholders, identify actions to achieve improved immunisation including but not limited to:

- Ensure 90% of newborn children are enrolled with a GP and Well Child provider at birth, by recording enrolment details on the maternity services birth event booking form
- Improving access to and coordination of immunisation services. We will do this by developing a coordinated, collaborative service delivery and governance model that identifies and addresses service delivery gaps and issues across the region, across all primary care providers, with a particular focus on Auckland and Waitemata DHBs
- The Auckland regional immunisation operations group will include PHO representation and will focus on practical systems related strategies for improving coverage. This group will report to the Auckland DHB immunisation governance group which will bring together all immunisation stakeholders, monitor performance and take a DHB broad systems perspective on improving coverage
- PHOs will be provided with regular practice level immunisation coverage data and analysis of the data
- Six month immunisation rate increases from 76% (1 March 2012) to 81% by 30 June 2013

Specific deliverables and measures

- 85% of 8 months olds are fully immunised by July 2013 (National Health Target: (85% in 2012/13, 90% in 2013/14, and 95% by 31st December 2014)
- Disparities in immunisation coverage are reduced
- A joint Auckland DHB/Waitemata DHB immunisation operations manager role is implemented
- 95% coverage of 2 year olds fully immunised is maintained

3.5 Tobacco

This is important for community and patients

Auckland DHB will work alongside Waitemata DHB and our primary care colleagues to reduce smoking rates. We will ensure that 95 percent of patients who smoke and are seen by a health practitioner in primary care or public hospitals are offered brief advice and support to quit. This requires having a referral pathway in place for advice and support to quit smoking across primary and secondary care. There will be open and accessible services to all people who smoke and we particularly want to do more for pregnant women, Māori, and Pacific patients.

Funding splits between primary and secondary care in 2012-13 will remain the same as for 2011-12 (approximate breakdown): primary care, 30 percent; maternity, 40 percent; and secondary care, 30 percent. The intention is that secondary care funding will contribute towards the development of greater integration between primary and secondary care.

How are we going to do this?

Smokers attending primary and secondary services care will be given advice to stop smoking on every admission or at every visit. They will have improved knowledge of and access to smoking cessation support including Nicotine Replacement Therapies and other pharmacotherapies as well as smoking cessation services. More pregnant women will be aware of the harm to the fetus caused by smoking. More people in the Auckland DHB area will successfully quit smoking.

We will put a system in place so that services can monitor their own progress toward meeting the national health target for tobacco. To provide better help for smokers to quit we will:

- Focus on pregnant women, Māori, and Pacific populations
- Work (alongside Waitemata DHB) with Primary Care Providers to develop plans showing how they will meet and maintain the Health Target
- Develop and implement a programme to increase referrals of pregnant women by GPs and private Lead Maternity Carers to promote smoking cessation services for pregnant women
- Improve data collection and monitoring systems in secondary care to help services view and manage their progress towards meeting and maintaining the health target

Specific deliverables and measures (as in the Northern Region Health Plan)

- 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking
- 90% or primary care enrolled patients who smoke will be provided with help and advice to quit
- 90% of pregnant women who come through National Women's health including community based services, are offered advice and support to quit

3.6 Respiratory

This is important for community and patients

Respiratory disease encompasses a number of different illnesses including high prevalence disorders such as chronic obstructive pulmonary disease and asthma, to high mortality diseases such as lung cancer and cystic fibrosis. Patients with respiratory disease tend to be more deprived and many diseases have a high prevalence in Māori and Pacific.

How are we going to do this?

During 2012-13 we will work with the Northern Region to better understand the prevalence and impact of respiratory diseases. We will also work with existing regional clinical networks in diabetes, child health, cancer and CVD to develop clinical pathways for respiratory conditions.

Specific deliverables (as documented in the Northern Region Health Plan)

- We will capture the rate of hospitalisations with respiratory DRG by age and ethnicity
- We will capture the number and rate of enrolled patients who complete a community based pulmonary rehabilitation programme.
- Develop a whole of system COPD clinical pathway
- Develop a tool for measuring the prevalence of co-existent diabetes and obstructive sleep apnoea syndrome
- Develop a clinical pathway for the management of lower respiratory tract infections in children
- 120 completed rehab programmes in the community

3.7 Cardiovascular Disease and Diabetes

This is important for community and patients

Over 800 Auckland residents die of ischaemic heart disease, stroke and diabetes every year. Of these, just over 170 are avoidable mortalities.

Cardiovascular disease when present with diabetes compounds the clinical risk for people and increases their likelihood of having more health problems. This continues to be a priority area, with the Ministry of Health making 'More Heart and Diabetes Checks' one of the top six health targets for the country. The national target is for 75% of the eligible population to have a CVD risk assessment by 30 June 2013. We will also continue to improve care for people with diabetes and our approach is covered in our Diabetes Care Improvement Plan.

In 2012-13 we will make sure that the people of Auckland DHB receive a risk assessment for cardiovascular disease and treatment for clinical risk factors and clinical conditions to minimise complications that arise from cardiovascular disease and diabetes.

To date, Auckland DHB cardiovascular risk assessment rates are as follows: (the data is split by Host PHO and therefore includes Auckland PHO and ProCare Networks which cover 3 DHBs)

- 42.4% total eligible population (PHO performance programme, December 2011)
- 51.6% high needs population (PHO performance programme, December 2011, Māori Pacific and Q5)

Annual Diabetes review rates (Q3 MOH reported results, April – December 2011)

- 59% total eligible population
- 58% Māori
- 65% Pacific

Diabetes good management rates (Q3 MOH reported results, April – December 2011)

- 77% total
- 70% Māori
- 60% Pacific

How are we going to do this?

Cardiovascular disease

- Support General Practice in the use of a population audit tool and electronic clinical decision support tool to identify their eligible populations and proactively contact and invite people due for risk assessment and risk reviews
- Auckland DHB funded Long Term Condition Coordinators will work with practices to proactively recall and invite people due for risk assessment and risk reviews

- Realign our current CVD risk management contracts to better support primary care to achieve targets
- Support the use of decision support systems that are based on NZ cardiovascular disease guidelines to support systematic evidence based management interventions
- Implement a secondary guideline-based electronic risk assessment and pathway system that promotes evidence based care, care planning and discharge planning (Acute Predict)
- Identify people who have had a recent CVD event so that they have access to appropriate rehabilitation
- Auckland DHB will work with the Northern Region Cardiovascular Clinical Network to implement their agreed strategies to improve CVD risk assessment rates in primary care and community settings

Diabetes

- Support practices to identify and manage patients with diabetes, as well as those who are currently at risk of developing diabetes, through use of a population audit tool
- Continue to support the objectives of the Regional Clinical Network, specifically the completion of the Diabetes Clinical Pathway
- Continue the development of diabetes retinal screening services in the community
- Auckland DHB will continue to work with practices to deliver diabetes annual reviews

Diabetes Care Improvement Package

Following consultation with PHOs, the agreed overall aim of the Diabetes Care Improvement Package is to reduce inequalities in diabetes care and management in Auckland DHB. Funding will therefore be focused on Māori, Pacific and Quintile 5 population from 15 years of age onwards. Summary activity is included in this section, with a paper outlining the full Ministry of Health requirements for the Diabetes Care Improvement Package in Appendix 3.

Self management

Deliver evidence based support designed to help people manage their long term conditions to the best of their ability:

- Continued rollout of the Stanford chronic disease self management programme through the Healthy Village Action Zone framework
- Provide appropriate support for self-management of long term conditions particularly CVD and Diabetes
- Provide effective services tailored to the needs of high risk population groups

Shared Care

- Facilitate access to summary health information 24/7, and improved coordination and multi-disciplinary care planning through participation in the National Shared Care Planning programme

Specific deliverables and measures

Diabetes and Cardiovascular disease

- 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years, to be achieved in stages by 1 July 2014. The first stage is to achieve 60 percent by 30 June 2012, and 75 percent by 30 June 2013 (supports our regional target)
- A minimum of 25% of retinal screening will be undertaken in community settings, with a minimum of 1,000 retinal screens in the community
- 60% of people (broken down by ethnicity) have an annual diabetes review completed in primary care
- 76% of patients (broken down by ethnicity) with good diabetes management (HbA1c ≤ 64mmol/mol) at time of diabetes review

Shared Care

- Respiratory, cardiac rehab, renal services will be engaged and participating in Share Care Planning by Dec 2012
- General Medicine will have a planned timeline for participation in Shared Care with at least one General Medicine team actively participating
- 100% of participants in the shared care programme to receive a shared care plan

Self Management

- A minimum of 15 Diabetes self management courses will be delivered with a focus on our high needs population groups
- A minimum of 6 Long Term Conditions self management courses delivered for Pacific people through the Healthy Village Action Zone model

3.8 Cardiac Services

This is important for community and patients

Cardiac disease is a major cause of death, illness and disability in our population and a large component of ethnic differences in life expectancy within Auckland DHB. There are many effective medical and surgical treatments that can reduce the burden of disease but these depend upon good access to diagnostic services and specialist assessment as well prompt intervention where appropriate. We need to reduce our waiting times for these services in order to maximise health benefit to our population. We also need to ensure that Māori and Pacific receive equitable access to these services.

Our local actions to reduce the growth and burden of cardiovascular disease are part of the wider regional programme of work. The regional work programme aims to achieve clinically appropriate, timely and equitable levels of access across the region to key cardiac assessment services and to optimally mange the patient journey from the community through primary, secondary and tertiary care. The following activities align to the region work plan.

How are we going to do this?

- Patients with suspected Acute Coronary Syndrome receive seamless co-ordinated care across the clinical pathway through improved communication and education of staff
- Establish Chest Pain clinics to reduce wait times for First Specialist Assessment for people who have developed cardiac symptoms
- Improving access to primary acute percutaneous coronary intervention (PCI) through greater links with ambulance services and other hospitals for transmission of ECGs

Specific deliverables and measures

Cardiac surgery targets identified and agreed with the National Cardiac Clinical Network

- Agreement to, and provision of, a minimum intervention rate of 6.2/100,000 eligible population for bypass cardiac surgery discharges in 2012-13
- Agreement to, and provision of, a minimum intervention rate of 11.9/100,000 eligible population for PCI discharges in 2012-13
- Agreement to, and provision of, a minimum intervention rate of 32.3/100,000 eligible population for coronary angiography discharges in 2012-13
- Greater than 85% percent of patients will receive elective coronary angiograms within 90 days, and no patient will wait longer than six months
- The baseline for equity of access for cardiac surgery be established by August 2012 and a strategy for address inequities will be developed by March 2013

- Improved capacity will be achieved through a 4th operating room in use from July 2012 and an additional surgeon from December 2012
- Formalised agreements for additional capacity with private and other public providers will be in place by July 2012

Cardiac rehabilitation services for Māori

- Identify enablers and barriers to accessing cardiac rehabilitation services for Māori. Prioritise and implement changes
- Develop strategies to maximise the effectiveness of cardiac rehabilitation services for Māori

Improve responsiveness and performance of acute hospital care (as documented in the Northern Region Health Plan)

- 70% of patients with suspected cardiac condition (non-acute) have a First Specialist Assessment within 6 weeks
- 70% of patients with acute myocardial infarction will undergo primary angioplasty door to balloon time of less than 90 minutes
- 70% of patients presenting with an Acute Coronary Syndrome will undergo angiography within 72 hours of admission
- The baseline for equity of access for acute hospital care (for cardiac) to be established by Dec 2012 and a strategy for addressing inequalities will be developed by June 2013

Cardiac Rehab

- 75% of people with a diagnosis of acute coronary syndrome (recent CVD event) have attended an education support session
- 75% of people with Acute Coronary Syndrome assessed for cardiac rehabilitation attend a Phase II rehabilitation course
- The baseline for Cardiac Rehab services be identified by August 2012

3.9 Service integration: Primary care development and delivery

This is important for community and patients

The combined Auckland and Waitemata DHB 'integrated locality approach' is our key mechanism to progress the integration of community, primary care, and secondary care into a more cohesive, accessible, effective, safe and sustainable system. Integration is important for improving patient outcomes and experience, while addressing the demands on primary and secondary care capacity caused by a growing and aging population, increasing expectations around quality of clinical outcomes and global and national economic challenges.

Our approach involves:

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

The localities approach integrates activity across three key areas: our use of health information; engagement of local communities; and service provision and development. It offers real potential to allow a significant departure from current models of service delivery, including the potential to design and deliver services more collaboratively with patients and their families through community engagement and the use of co-design tools and techniques.

Progress to date

- West Auckland Health Network (consisting of primary care and DHB secondary care clinicians and community representatives) has been established with a framework of agreed principles, initial objectives and high level capacity requirements
- Quantitative local health needs assessment data compiled and presented in an interactive geographic format across all Auckland and Waitemata DHB Local Board areas
- Space has been leased and DHB services are being delivered within Whanau House in Henderson
- Space leased in the New Lynn Integrated Family Health Centre for delivery of DHB services in 2013-14

- The Greater Auckland Integrated Health Network (GAIHN) annual plan projects are on track for 2011-12 delivery in areas such as Primary Options for Acute Care (POAC), predictive risk analysis, minor skin surgery, and access to diagnostics
- 1,200 Minor Surgery procedures delivered in the community (Counties Manukau DHB 400, Waitemata DHB 500, Auckland DHB 300) and 20,000 Primary Options for Acute Care referrals for 2011-12
- New clinical pathways for Gout, Depression, Chronic Obstructive Pulmonary Disease (COPD), Transient Ischaemic Attack (TIA), and Pneumonia
- Implementation of an agreed Auckland Regional After Hours Network

How are we going to do this?

Implementation of the Integrated Locality Approach will require the formation of novel groups based around new partnerships and ways of working. The oversight and delivery of the locality approach is proposed to occur as follows:

A combined Auckland DHB-Waitemata DHB *Integration Steering Group* including key primary and secondary clinicians, and DHB Planning and Funding staff will provide overall strategic direction and governance

Integrated Health Networks (IHNs) bring together primary and secondary care clinicians, the community, and other key stakeholders to enable clinicians and local communities to be at the forefront in determining local health priorities, co-designing new models of care and driving quality improvements for the purpose of improving the design and delivery of local health services

Clusters of providers that operate in a distinct geographical area under a broader Integrated Health Network will look at service design and provision for the enrolled populations

Locality planning - Integrated Health Networks will decide joint service priorities and efficient care models. Locality planning will advance Whanau Ora approaches to health improvement for high need groups

- Implement 3 Integrated Health Networks
- Implement overarching governance mechanism for integrated care across Auckland and Waitemata
- Develop enduring partnerships with local communities
- The Integrated Health Networks to identify and assess opportunities where there is sufficient volume to enable integration or co-location of secondary care services with primary care

Integrated services closer to home - Primary Care Delivery Options for integrated care will be jointly agreed across all parts of Auckland and Waitemata DHBs (i.e. primary, community and the provider-arms/Healthcare Service Groups):

- Develop integrated models of care in the two priority areas of diabetes and child health through Clusters by June 2013
- Deliver, through the Auckland Regional After Hours Network, access to free after hours care to under 6's

- Deliver Better, Sooner and More Convenient care for people by delivering more services in the community (retinal screening, dialysis, pulmonary rehab, non-contact First Specialist Assessments with referral back to primary care with specialist advice) – Auckland DHB specific
- Explore integrated model of care for sexual health services

Better management of high risk individuals - Proactive management of these individuals prior to ambulatory sensitive hospitalisations

- Auckland DHB Health of Older People Services specialists (geriatricians, gerontology nurse specialists) will be used to advise and support health professionals in primary care and aged residential care – Auckland DHB specific
- Implement GAIHN shared care planning for high risk individuals using the GAIHN predictive risk planning tool, and better response to acute events in aged care residences workstreams
- Decrease inpatient Length of Stay (LoS) using Auckland DHB inpatient risk stratification tool and leveraging community setting to support discharge – Auckland DHB specific
- Devolve all non complex clients to Home Based Support Services and community providers to allow full implementation of the revised community integration model for older people – Auckland DHB specific
- Work with the National Hauora Coalition to develop an integrated service framework for all agreed primary care contracts within the scope of Mama, Pepi, Tamariki for its enrolled population completed and ready to be operated by July 2013 – Auckland DHB specific

Optimum management of long term conditions - More patient-centred care that supports self management of long term conditions

- Local implementation of the regional quality improvement plan for diabetes (via the West Auckland Health Network)
- Implement GAIHN's clinical pathways in Chronic Obstructive Pulmonary Disease (COPD) and Depression and the regional Dementia pathway – Auckland DHB specific
- With the National Hauora Coalition, agree and develop an integrated service framework for all agreed contracts within the scope of Oranga Ki Tua (long term conditions) completed by Quarter 3 and ready to be operated from July 2013 – Auckland DHB specific
- Work with Alliance Health + in its realignment of business case and clinical framework for implementation in 2012-13 – Auckland DHB specific
- Case management and care coordination of Māori and Pacific people with long term conditions through integration and collaboration with Te Honanga Whanau Ora long term condition service – Auckland DHB specific

Better response to acute events in the community - Extend Primary Options for Acute Care and Primary Care Transporting Options

- Deliver regional Primary Options for Acute Care (POAC) volumes in line with regionally agreed criteria, targets and timeframes
- Support GAIHN Primary Care Transporting Options for Auckland Ambulance for select patients to be treated at community Accident and Medical facilities or their 'medical home'/GP (20% of all status 3 and 4 patients transferred by St John to a primary care setting instead of Emergency Departments) – Auckland DHB specific

- Support the GAIHN approach to management of acute events in residential care (both in and out of hours)

Specific deliverables and measures

Locality Planning

- 3 Integrated Health Networks (Central Auckland, North Auckland and West Auckland) operating across Auckland DHB and Waitemata DHB by June 2013
- Initial assessment of patients' view about their health status, service delivery, and priorities in 2 Auckland DHB Local Board areas. Completed by September 2012 -- Auckland DHB specific
- Community representation groups established in 2 Auckland DHB Local Board Areas by December 2012 -- Auckland DHB specific
- Co-designed locality plan for Auckland Central submitted to the Ministry of Health by 31 March 2013 -- Auckland DHB specific
- Jointly agreed locality plan for Auckland West locality submitted to the Ministry of Health by 31 December 2012
- Jointly agreed locality plan for Auckland North locality submitted to the Ministry of Health by 31 March 2013
- A diabetes care pathway developed and implemented in West Auckland by December 2012 : (development in Q1 and implementation in Q2)
- A child health care pathway based on the priority areas identified in the Auckland DHB/Waitemata DHB Child Health Plan developed and implemented by June 2013 (area identified in Q1, development completed in Q3, implementation in Q4)

Integrated Services closer to home

- Up to 4 Integrated Family Health Centres operational in Auckland DHB and Waitemata DHB and delivering at least 4 models of integrated care by June 2013
    - New Lynn Integrated Family Health Centre operational and delivering new models of care in line with West Auckland's locality plan by 2013-14
    - Whanau House in Henderson delivering new models of integrated care by June 2013 (engagement with surrounding community representatives and practices in Q1, developing a new model of care in Q2, and implementation in Q3/4)
    - Co-design process in place to explore new models of care within the development of Waiheke Integrated Family Health Centre by June 2013
    - Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres (engagement with surrounding community representatives and practices in Q1, developing a new model of care in Q2, and implementation in Q3)
    - Review current integrated care models being delivered in rural settings (Rodney) by December 2012 for potential networking between Integrated Family Health Centres in 2013-14
- DHB services to be delivered in Henderson and New Lynn Integrated Family Health Centres determined (engagement with community, primary and secondary care in Q1, service delivery volumes and business case in Q2, Board approval in Q3)

- A working group established to review and reshape funding models for integrated care (including nurse led clinics) by March 2013 (working group established in Q2, contracts potentially reshaped in Q3) -- Auckland DHB specific
- Auckland DHB, in partnership with Counties Manukau DHB, provide nursing leadership to support Alliance Health + to develop nurse led clinics by March 2013 -- Auckland DHB specific
- 95% of metro Auckland's population can access free under 6's after hours services by June 2013 (baseline in Q1 and quarterly targets set for Q2, Q3 and Q4)
- Work with a Māori primary care provider to develop an Adult Haemodialysis unit in Glen Innes, with the capacity to deliver up to 1,000 Nephrology reviews per annum and 7,000 dialysis treatments per annum by December 2013 (subject to Board approval) -- Auckland DHB specific
- 30% of retinal screenings (3,000) performed in a community setting by June 2013: (650 in Q1, 750 in Q2, 750 in Q3 and 850 inQ4) as this is a new initiative, the current baseline is 0 retinal screenings performed in the community -- Auckland DHB specific
- Increase non-contact First Specialist Assessments by 4% each quarter (16% in total) by June 2013 -- Auckland DHB specific

Better management of high risk individuals

- 10% reduction in number of residents from aged care facilities presenting to Adult Emergency Department through GAIHN's project to improve primary care support within facilities by June 2013 (determine baseline in Q1 and set trajectory for Q2, Q3 and Q4)
- A total of 800 Nurses and Health Care Assistants from Aged Residential Care will attend dedicated specialist training provided and funded by Auckland DHB by June 2013 (200 in Q1, 200 in Q2, 200 in Q3, 200 in Q4) -- Auckland DHB specific
- In quarter 1, baseline and develop an avoidable admissions plan for high risk individuals identified by the GAIHN Predictive Risk Algorithm. In quarter 2 set a regional target (and specify Auckland DHB contribution) for a percentage decrease in growth of bed days for identified individuals, in Q2,Q3 and Q4 to be delivered by June 2013
- Support the National Hauora Coalition to reduce ASH rates for under 2 year olds by 1% from baseline
- Implement an inpatient risk stratification tool for identifying potential stranded patients (patients with LOS >42 days) and determine baseline in Q1, achieve 10% reduction by Q2, 20% by Q3 and 50% reduction by Q4 – Auckland DHB specific
- 10% (~165) reduction in readmission rates for people over 75 years of age: current baseline is 1,657 readmissions

Optimum management of long term conditions

- A diabetes care pathway developed and implemented in West Auckland by December 2012: (development in Q1 and implementation in Q2)
- 60% of diabetes patients aged 15-79 have a diabetes Annual Review by June 2013
- Implementation of GAIHN's regional pathway for Chronic Obstructive Pulmonary Disease (COPD) by March 2013 (engagement and planning in Q2, Implementation in Q3) –Auckland DHB only
- Deliver 120 completed pulmonary rehab programmes in the community by June 2013: (30 in Q1, 30 in Q2, 30 in Q3 and 30 inQ4) current baseline is approx. 100 patients -- Auckland DHB specific
- Implementation of GAIHN's regional clinical pathway for depression by June 2013 (engagement and planning in Q3, Implementation in Q4) -- Auckland DHB specific

- A dementia pathway, which is regionally consistent wherever possible, will be developed by 30 June 2013

Better response to acute events in the community

- Deliver, in collaboration with Waitemata DHB/Counties Manukau DHB, 23,500 Primary Options (POAC) episodes of care across metro-Auckland, resulting in at least 19,975 avoided attendances at hospital emergency departments by June 2013
    - 5,700 POAC episodes of care in Auckland DHB resulting in at least 4,845 avoided attendances at Emergency Department (up from ~4,240 cases in 2011-12)
    - 6,150 POAC episodes of care in Waitemata DHB resulting in at least 5,227 avoided Emergency Department attendances (up from 2011-12 target of 5,200 cases)
- 2,000 bed day reduction in Acute admissions from aged care sector across the northern region by June 2013
- Align radiology costs for Primary Options for Acute Care and Access to Diagnostics and front line processes by December 2012 -- Auckland DHB specific
- By end of Q1 of 2012-13, agree an appropriate regional target for waiting times for accepted routine community referred radiology

3.10 Community and Outpatient Access to MRI and CT Imaging

This is important for community and patients

Work in this area means people in our community who have been referred for Magnetic Resonance Imaging (MRI) or Computed Tomography (CT) Imaging by their GP or specialist, will have faster access to diagnostics. Reduced waiting times for diagnostics means people will have better outcomes and improved quality of health services.

There has been a significant growth in the demand for both CT and MRI at Auckland DHB over recent years (9% per annum for CT 12.2% per annum for MRI). The growth in CT referral demand has been partly offset by the faster scanning times made possible by higher specified CT scanners. However the increased MRI demand coupled with a focus to reduce outsourcing of MRI has resulted in a significant wait list of MRI referrals. The majority of these (waitlist) referrals are community and outpatient referrals.

In addition to its own facilities, Auckland DHB currently utilise the services of 3 private imaging providers for both CT and MRI. Access to diagnostics in primary care is covered in the previous section.

How are we going to do this?

Access to CT (Computed Tomography) Imaging

- Increase the capacity of Imaging at Auckland City Hospital by reviewing the operations and implementing productivity improvements (Target - 10% increase in capacity)
- Continue with the Introduction Patient Focused Bookings for outpatient and GP referrals for CT to reduce patients who Did Not Attend (DNA) and therefore reduce the waiting list (Target – reduce DNAs by 5%)

Access to MRI (Magnetic Resonance Imaging): Reduce the backlog of existing MRI imaging (currently 1,400 overdue) to a wait time of less than 6 weeks by:

- Reviewing the waiting list and identifying / removing any imaging that is no longer required or duplicated
- Re-prioritising the remaining waiting list
- Process the remaining waiting list to bring it to within 6 weeks by:
    - Outsourcing and/or
    - Increasing operating hours of Auckland DHB's MR facilities
- Improve the processes to manage demand for new referrals for MRI

- Work with clinical services (referrers) and community providers to agree on clinical referral protocols for MRI
- Identification and management of referrals that could be done outside Auckland DHB (e.g. non-Auckland DHB domiciled patients) and contacting other DHB's regarding these onward referrals
- Identify any referrals that are outside of the agreed protocols
- Implement a process to manage incoming referrals and provide feedback channels to referrers where they are outside the agreed standard

Increase the capacity of Auckland DHB's MRI to meet the demand within target timeframes

- Maintain the recent productivity improvements made to Increase the capacity of MR Imaging at Auckland City Hospital and Starship (with existing budgeted resources)
- Increase the operating hours of the Auckland DHB magnets by funding additional MRT and nursing staff to meet demand as per the business case
- Commission a new magnet at Greenlane Clinical Centre as per the business case

Specific deliverables and measures

Access to CT (Computed Tomography)

- Increase the community and outpatient referrals for Computed Tomography seen within 6 weeks from 72% to 75% by June 2013

Access to MRI (Magnetic Resonance Imaging)

- Reduce the backlog of all overdue MRI referrals to be under 6 weeks waiting (excluding planned referrals for future dates) by June 2013. (this is equivalent to processing 1,400 referrals)
- Maintain the community and outpatient referrals for Adult MRI seen within 6 weeks from 33% through to June 2013 (At present demand is exceeding capacity)
- Maintain the community and outpatient referrals for Paediatric MRI seen within 6 weeks from 30% through to June 2013 (At present demand is exceeding capacity)
- Move towards increasing the community and outpatient referrals for Adult MRI seen within 6 weeks to 75% from July 2013
- Move towards increasing the percentage of community and outpatient referrals for Paediatric MRI seen within 6 weeks to 75% from July 2013

Reporting against activities

- Provide information monthly to meet the requirements of the national performance measure (Developmental Measure 2: Improved waiting times for diagnostics)

3.11 Mental Health and Addictions

This is important for community and patients

Improving consumer access to mental health and addiction services is a key objective so as to allow intervention at the earliest point. Tangata whai i te ora and whānau will have improved access to clinically and culturally appropriate mental health and addiction services when needed.

Prompt access to relevant mental health and addiction services is achieved through several mechanisms including the development of care pathways and entry points for consumers in primary care services and the wider community. This would include better access to specialist services support in primary care and include, for child and youth mental health services, access to specialist services through a care pathway for referrals from schools and well child providers.

In future, people should experience greater integration across the various services they use, particularly between generalist and specialist mental health services. We want to improve access to a range of services for both low and high severity mental health and addiction problems and this means providing services at convenient points, whether in generalist primary care / wider community context, or specialist services.

We seek to support all health care staff including the mental health and addiction workforce in delivering sound self-management skills and building resilience for consumers and others with mental health and addiction concerns. There will be improved access to training and development for staff in specific mental health and addiction services across the care continuum as we better understand the needs of our workforce. We will demonstrate increased uptake of Child and Youth specific CEP/Alcohol and other Drug training in collaboration with Waitemata DHB to enhance capacity.

Residential rehabilitation services will be better tailored to consumer needs allowing for more independent living where possible. Access to facilities will be improved so there is better intensive rehabilitation and a more effective response to people with complex or multiple needs. In particular we will reconfigure NGO youth residential Alcohol and Other Drug services to increase flexibility and improve outcomes by providing resettlement support for ex-residents and thereby build resilience. These workers will link with the school-based youth Alcohol and Other Drug service that has already begun. This will then increase capacity for early interventions and reduce wait times.

If consumer needs are identified earlier then this should reduce demand for more resource intensive or more specialist services later. Access to Primary Care services also ensures the improved physical well-being of consumers with high severity lower prevalence mental health problems.

Focussing on building people's resilience, improving access to and the timely responsiveness of specialist services will also assist in reducing the impact over time of severe mental health and addiction problems. Recognising that mental health and addiction problems require a medical, psychological, and social response, we will champion the coming together of different agencies and sectors to support these objectives knowing that costs can be reduced and outcomes improved. This will mean that consumers receive a more integrated and connected service that better meets their range of needs.

How are we going to do this? (aligns to activity covered in our region's health plan)

Child and Youth Mental Health

- Increase the capacity of the child and youth continuum (NGO and DHB Clinical) to respond to demand by development of care pathways from schools and Well Child providers and closer working with Child Youth and Family Services
- Ensure that adolescents and young people have access to appropriate and accessible services in the community by improving integration with primary care and community providers
- Develop pathways to improve integration and collaboration with paediatric and primary care services
- Adopt components of Choice and Partnership Approach to enable improved accessibility to Child and Adolescent Mental Health Services for young people

Primary Mental Health

- Develop care pathways to facilitate earlier access to generalist and community based specialist mental health and addiction services
- Support the implementation of a clinical pathway for depression
- Increase specialist support to primary care (regional target)

Improve Mental Health and Addiction Services

- Develop improved physical health care for mental health and addiction consumers with high severity lower prevalence problems
- Improve waiting times for non-urgent mental health and addiction problems
- Investigate, analyse, and modify services to reduce wait times
- Improve support services for high severity lower prevalence consumers and track appropriate continuing support e.g. online support
- Build resilience and strengthen recovery (regional target)
- Develop workforce capability in services for vulnerable populations, those with high severity lower prevalence problems, and long term conditions (regional target)

Māori Mental Heath

- Develop and implement an iwi-based Māori mental health model across the mental health continuum of care
- Utilise Kaupapa Māori mental health NGO in planning iwi-based services

- Review and analyse Māori mental health workforce profile (regional)

Specific deliverables and measures

Child and Youth Mental Health

- Improved access rates to DHB Clinical and NGO services at, or better than, the identified indicators (2.53% for Total) 0 to 19 years (known as 'PP6' indicator by Ministry)
- Reducing waiting time for access to non-urgent mental health and addictions services so that performance is at or better than the identified indicators (as agreed with the Ministry) (known as 'PP8' indicator by Ministry)

Primary Mental Health

- Completed care pathway for one mental health area by June 2013
- Establish, by June 2013, baseline and targets for: consult liaison contacts, and Mental Health programmes for primary care

Improve Mental Health and Addiction Services

- Investigate method to monitor and then improve access to physical health assessments for longer term community clients (those at Community Mental Health Centres)
- 75% of those referred for non-urgent mental health and addiction problems seen within 3 weeks (PP8 indicator used by Ministry)
- 85% of those referred for non-urgent mental health and addiction problems seen within 8 weeks (PP8 indicator used by Ministry)
- Wait times project started by November 2012 with focus on investigating options to shorten waiting times in DHB and NGO Mental Health and Alcohol and Other Drug Services
- Fully implement 'Knowing the People Planning' within the Adult specialist Mental Health and Addiction services by June 2013
- Implement online support service by September 2012
- Introduce flexible delivery in NGO support contracts by August 2012
- >85% of NGO residential rehabilitation contracts modified to support new approach, June 2013
- Mental Health for Older People e-learning available by August 2012 (regional activity)
- Eating Disorders e-learning available by June 2013 (regional activity)

Māori Mental Heath

- Develop and pilot a cultural and clinical partnership model in Te Whetu Tawera by June 2013
- All Mental Health and Addiction NGOs complete iwi endorsed Māori health plans (as contractually required) by September 2012
- Review completed by December 2012

3.12 Health of Older People

This is important for community and patients

We are working to make sure older people get more streamlined and targeted assessment of their needs. This means reducing duplication in assessment and having timely re-assessment where needs are changing. Following the assessment we need more targeted and specific interventions with greater consistency of access.

In particular we want to expand the range of funded and unfunded disability support services. Ideally these should be as close to a person's home as possible. Also the more we can offer in the community, through GPs and others, the better. This keeps people out of hospital and makes for streamlined services across primary and secondary services.

The approach is based on achieving person-centred goals. Service interventions should also be based on clinical information.

Primary care is a key partner in improving our service coordination for vulnerable elderly, and activity will be jointly planned across DHB and Primary Care workstreams to achieve maximum impact in the 2012-13 year.

We will increase access to early onset dementia services. We will help to develop a greater range and level of skill within the Aged Residential Care sector. Overall, we want to see safer practice in working with older people across both inpatient and community settings. This will also depend on increasing service accountability and the reporting of clinical issues.

The following activities align to the programme of work in our Northern Region Health Plan.

How are we going to do this?

Quality home and community support services for older people

- Older people receiving long term Home Based Support Services will have regular Comprehensive Clinical Assessment using any of the interRAI assessment tools
- Benchmarking will be undertaken across the region and with the bigger comparative national DHBs to ensure that assessments are being undertaken and interpreted in a consistent way
- Increased flexibility of services will be possible through the use of packages of care and casemix funding
- Enhanced Home Based Support services, along side specialist services and primary care will be integral in our early discharge process project and our plans to implement interim care solutions to reduce length of stay
- As part of the Regional discussion, ARC facilities will be supported with a centralised primary care system that will provide alternatives to admission, particularly after hours. Auckland DHB will

utilise its share of Pharmacy savings to further enhance solutions that are already underway in this area

Comprehensive Clinical Assessment in residential care

- We will work with the Aged Residential Care sector to support facilities to implement a Comprehensive Clinical Assessment tool for all residents

Dementia pathway

- A dementia pathway, which is regionally consistent wherever possible, will be developed by 30 June 2013
- Pharmacy savings will be used to ensure that a regionally consistent dementia pathway will be developed by 30 June 2013 in conjunction with Primary Care and NGOs across the region

Community specialist Health of Older People teams

- Proactive use of DHB specialist Health of Older People Services (geriatricians, gerontology nurse specialists) will be used to advise and support health professionals in primary care and aged residential care
- Devolution of complex clients to community agencies will ensure a more focused approach to service delivery for community clients as determined by the casemix clinical coding project
- Devolve all non complex clients to Home Based Support Services and community providers to allow full implementation of the revised community integration model for older people

Specific deliverables and measures

Quality home and community support services for older people

- 100% of people receiving long term Home Based Support Services have a Comprehensive Clinical Assessment (using any of the interRAI assessment tools) within the year
- 80% of clients assessed as being socially isolated receive services to reintegrate them into community and natural supports
- 100% of Home Based Support Services clients have a documented long term goal that they have been involved in setting, as well as clear identified steps to achieve them
- Auckland DHB will access and track readmission rates for people over 65 years of age

Comprehensive Clinical Assessment in residential care

- 50% percent of long term residents in the number of facilities set out in the implementation plan have a care plan developed by utilising Comprehensive Clinical Assessment

Dementia pathway

- All clients with cognitive decline receiving Home Based Support Services will be managed according to the agreed care pathway

Community specialist Health of Older People teams

- A total of 800 Nurses and Health Care Assistants from Aged Residential Care will attend dedicated specialist training provided and funded by Auckland DHB

- A total of at least 200 Aged Residential Care clients will be case managed, or provided a consult and liaison service by Auckland DHB Aged Care specialist nurses
- The After Hours Primary care support to Aged Residential Care model will be finalised and trialled
- The caseload of complex Home Based Support Service clients for specialist services will reduce to less than 100 per clinician at any one time.
- Education and support by specialists to the generalist sector as demonstrated by an increase in consults and joint visits by 25%

3.13 Stroke Services

This is important for community and patients

The impact of strokes and transient ischemic attacks (TIAs) on individuals and their whanau and family is significant. There is a very high risk of death. For those that survive, the disability caused by the stroke can impact on the ability to work and live independently. The disability often requires support from family and external help to support the person, at significant emotional and financial cost.

Strokes in the under-65 age group are particularly challenging because of the loss of income and impact on young families.

How are we going to do this?

Auckland DHB already has a specialised Adult stroke unit, so in the next year in collaboration with the Northern region we will:

- Support GAIHN's stroke prevention programme which includes prevention initiatives such as a TIA awareness campaign for the population and refreshing stroke prevention key messages with primary care teams and partner organisations. The prevention project will also support the TIA clinical pathway rollout in primary care by assisting with education to practice teams, in particular for non-clinical staff. Part of the TIA pathway includes better access for urgent ultrasound by primary care

Specific deliverables and measures

- Continue to build on the baseline of 8% of ischemic stroke patients who are thrombolised (Auckland DHB is already ahead of the regionally agreed target of 6%)
- Continue to improve our current baseline of 80% of patients with a stroke who are admitted to our specialised stroke unit

3.14 Whānau Ora

This is important for community and patients

Whānau Ora provides the catalyst for improving the capability of health providers and hospital-based services to deliver high quality, integrated and responsive services to whānau and families. We will support this activity in our region by working closely with Te Puni Kokiri and the Whānau Ora Collectives to implement their approved Plans of Action. Additionally, we will support providers who have indicated that they would like to participate in the Ministry of Social Development's integrated contracting programme by supporting the integration of health contracts among those providers. Integrated contracts will focus more on achieving outcomes as opposed to outputs, and ease contract compliance to ensure that more resources are focused on frontline service provision.

The PHOs and 'Better, Sooner, More Convenient' business cases provide strong clinical and strategic leadership that will help guide developments across our region for Whānau Ora. We will work in partnership with these groups to support families and whānau accessing health services to receive more integrated packages of care closer to home, in particular the National Hauora Coalition and their Oranga Ki Tua and Mama, Pepi, Tamariki programmes.

With support from our manawhenua partners (Te Runanga o Ngāti Whatua) we will develop a Whānau Ora Integration Leadership Group made up of iwi and community representatives, primary and secondary healthcare clinicians, and representatives from outside of the health sector to oversee Whānau Ora in our district. This group will be charged with developing a Whānau Ora network in the Maungakiekie-Tamaki Ward that will support integration of services in that locality. Whānau Ora networks and Whānau Ora Centres will bring together both Te Puni Kokiri's Whānau Ora Collectives and BSMC business cases/PHOs supported by a Ngāti Whatua-led and Auckland DHB strategic context.

In the 2011-12 financial year, He Kamaka Oranga and Allied Health Social Work Services are jointly developing an inpatient Whānau Ora assessment tool that builds on the current assessment tool around the needs of whānau and families during their episode of care in hospital, and to better support their needs following their discharge from hospital. The tool ensures that they receive care, both whilst they are inpatient, and on their discharge i.e.; they are referred to appropriate support services within the community to better address their health and socio-economic needs, and reduce their likelihood of being re-admitted to hospital. We plan to utilise the tool initially in those Starship wards with high Māori utilisation rates. Inpatient Whānau Ora assessments will be provided by staff within the selected wards, and after evaluation, extended throughout the hospital.

The following actions align with the programme of work in our Northern Region Health Plan.

How are we going to do this?

Leading Whānau Ora across the region

- Whānau Ora Integration Leadership Group operational and supporting the implementation of whanau ora within Auckland DHB, spanning:
    - Whānau Ora centre developments
    - Whānau Ora network developments
    - Locality planning across the district, particularly in high needs areas
    - Collaboration between mainstream providers and Māori and Pacific providers on Whānau Ora service developments, provision, and planning
    - Integration between primary health, secondary health and specialist healthcare
    - Integrating services across sectors to support Whānau Ora delivery
- Develop a strategic view of priority sites for Whānau Ora collectives and networks across Auckland DHB, in partnership with Te Runanga o Ngāti Whatua, and consultation with Māori and Pacific health providers, BSMC business cases/PHOs, and Te Puni Kokiri Whānau Ora collectives

Supporting Whānau Ora among providers

- Support BSMC business case/PHO and Te Puni Kokiri Whānau Ora collective approaches to deliver whanau ora services within Auckland DHB
- Support Te Puni Kokiri by participating in the assessment of Whānau Ora Plans of Action for Collectives that are located within the Auckland DHB region
- Work with the two Whānau Ora Collectives in Auckland DHB (Orakei Trust Board and AH+), and any other emerging Collective in the district, to support implementation of their Whānau Ora Plans of Action
- Align strategic objectives of BSMC business cases/PHOs and TPK Whānau Ora collectives to Healthcare Service Groups' Health Improvement Plans

Integration

- Agree service integration implementation processes for all agreed contracts within the scope of Oranga Ki Tua and Mama, Pepi, Tamariki with the National Hauora Coalition
- Support the Ministry of Social Development's integrated contracting programme to improve the delivery of services to Māori, Pacific and other high needs families/whānau
- Host quarterly Auckland DHB Māori health provider fora that provide opportunities for integration and Whānau Ora among providers, and between providers and the DHB

Improving Services to better meet the needs of families and whānau

- Improve referral pathways between Auckland DHB inpatient services and health and social service providers in the community, and in other sectors, through the use of an assessment tool that identifies the needs of whānau/families post-discharge from the Auckland City Hospital and Starship Children's Health

Tikanga

- Implement year one priorities from the tikanga strategic plan
    - Appoint Tikanga Best Practice champions for each of the Healthcare Service Groups

- Audit the performance of three Healthcare Service Groups in implementing the Tikanga Best Practice Policy

Specific deliverables and measures

Leading Whānau Ora across the region

- Whānau Ora Integration Leadership Group operational by December 2012
- A Whānau Ora Working Group operational in the Maungakiekie-Tamaki Ward
- Te Runanga o Ngāti Whatua Whānau Ora Strategy confirmed by CPHAC October 2012
- Areas for the location of Whanau Ora Centres confirmed by December 2012
- A shared whānau ora outcomes framework between Ngāti Whatua, the DHB, Te Puni Kokiri Whānau Ora collectives and BSMC business cases completed by December 2012
- Support the development of a Ngati Whatua-led Whanau Ora Centre through the commitment of identified and agreed health services for location in, and provision from, the Centre

Supporting Whānau Ora among providers

- BSMC business case and Te Puni Kokiri whānau ora collective membership on the Whānau Ora Integration Leadership Group and Whānau Ora Locality Working Groups
- Auckland DHB representation on Te Puni Kokiri Whānau Ora Collective Plans of Action assessment panels
- Implementation of Te Puni Kokiri Whānau Ora collectives' Plans of Action. This activity will be measured against the achievement of Plans of Action objectives set by each Collective and agreed to by the Auckland DHB
- Whānau Ora and associated activity made explicit in Healthcare Service Groups' Health Improvement Plans

Integration

- Agreed contracts within the scope of Oranga Ki Tua, and Mama, Pepi, Tamariki identified by December 2012
- Implementation processes for each contract completed and ready to be operated from July 2013
- All health contracts held by Māori and Pacific health providers integrated into a single outcome-based contract per provider to reduce compliance issues, and better align activities to good health outcomes for families and whānau by 1 July 2013
- Quarterly Auckland DHB Māori health provider fora held

Improving services to better meet the needs of families and whānau

- Whānau Ora inpatient assessment pilot completed for Starship Children's Health, December 2012
- Evaluation of the pilot programme completed by January 2013
- Implementation of Whānau Ora inpatient assessment across Auckland City Hospital wards to commence on 1 February 2013, and to be completed before 1 July 2013

3.15 Child Health

This is important for community and patients

All children in our area should receive the health services they need, from Well Child and primary health care to acute services. The focus should be on ensuring that they get the best possible start to life while also ensuring that excellent hospital services are available when they need them. Healthy children have a reduced chance of acquiring long term conditions later in life.

Auckland DHB also provides specialist hospital services to children from all over the country. A project to improve inpatient accommodation for children and their and family/whanau will be undertaken. This will also result in improved hygiene and infection control and an improved working environment for staff.

We will collaborate with other Auckland DHBs in particular Waitemata DHB, primary care and other agencies to ensure that we meet the new immunisation target. This will include a move to 'joined up' service delivery models in order to reduce duplication and maximise synergies. Key projects will seek to improve levels of health literacy and early enrolment of infants with primary care, oral health and Well Child services.

Particular efforts will be taken to reduce inequalities between Māori and Pacific and non Māori, non Pacific. We will work with the other Auckland DHBs and primary care to reduce rates of Rheumatic Fever, SUDI, respiratory disease, avoidable injury and skin sepsis. Inequalities are evident in all of these conditions which also affect children from poorer families more frequently and more severely. Substandard housing is a common issue and on this and other issues we will collaborate effectively with other sectors such as Housing, Education, Ministry of Social Development and Auckland Council. We will actively participate in the Counties Manukau DHB led Rheumatic Fever Health Alliance Forum and work with the National Hauora Coalition to implement Rheumatic Fever sore throat clinics in Auckland DHB.

How are we going to do this? (aligns to the programme of work in our region's health plan)

Better, Sooner, More Convenient

- Work with GAIHN in the first instance, to develop and implement clinical guidelines for management of asthma and skin sepsis in primary care, building on existing Starship Clinical Guidelines
- Support the National Health Coalition's Mama, Pepi, Tamariki programme to deliver on improved breastfeeding rates, oral health, B4SCs, immunisation coverage and ASH rates for under 2 year olds (respiratory conditions in particular) and rheumatic fever

Collaboration

- Develop systems for seamless handover of mother and child as they interact with the health system: antenatal care, Lead Maternity Care, birth, Well Child, Tamariki Ora, primary care
- Collaborate with Waitemata DHB and primary care to implement a joint Child Health Improvement Plan that includes clinical services and focuses on our children as one population
- Continue to refine the B4SC service delivery model to ensure that all Auckland DHB 4 year olds have access to the programme and begin school healthy and ready to learn
- Work with the Northern Regional Rheumatic Fever Alliance Group, which includes primary care, to implement sore throat clinics in at least 4 identified high need schools
- Ensure that all eligible children are able to access core Well Child Tamariki Ora services that meet their needs
- All infants and children identified through Well Child Tamariki Ora needs assessment and through the B4SC as having needs, are referred for appropriate specialist or other advice or care

Development of Starship

- Complete a detailed options analysis regarding Starship's physical facilities, taking into account the projected demand for national paediatric tertiary specialty services, Auckland DHB secondary paediatric services and regional collaboration for capacity development
- Complete the design for refurbishment of the level 6 medical sub-specialities wards at Starship and commence these works during the current year (anticipate project to be completed by June 2013)
- Agree on the preferred solution for resolving Starship Operating Rooms capacity constraints (based on point 1 above), and develop the project plan for this work to occur during 2013-2014

Whanau Ora

- Develop and implement a school based health initiative in at least two Māori medium education settings. This will foster relationships between primary healthcare providers, schools and whanau; promote and increase the uptake/awareness of health initiatives targeted at children, youth and whanau, utilising the schools' existing relationships with whanau

Oral Health

- Develop plans and strategies in conjunction with Auckland Regional Dental Service, the Māori and Pacific DHB teams and pre-school coordinators to get more Māori and Pacific pre-school aged children enrolled and at an earlier age

Breastfeeding

- Determine the effectiveness of the current breastfeeding services and strategies, particularly for Māori and Pacific, including the Community Breastfeeding Service and Baby Friendly accreditation (both BFHI and BFCI).

Specific deliverables and measures

Better, Sooner, More Convenient

- Starship Clinical Guidelines for the management of asthma and skin sepsis implemented in primary care by June 2013

Collaboration

- 100% newborns are enrolled with a PHO and Well Child service at birth
- Effective regional child health fora are in place that are inclusive of clinicians, primary care, NGOs, and other sectors, as well as maternity and mental health representation as appropriate
- Implement recommendations of the Well Child Tamariki Ora Quality Review as agreed and implement a Quality Improvement Framework across all providers (including the B4SC programme) – within six months of receipt of the review outcomes
- Further develop the B4SC Service Alliance delivery model to ensure that children are able to be located by working in collaboration with other providers and sharing information so that 80% of all eligible children receive a Check
- Timeliness of access to referred services is monitored
- All Well Child Tamariki Ora and B4SC providers use an approved and/or appropriate needs assessment tool
- Child health objectives relating to SUDI, Rheumatic Fever, skin sepsis, avoidable injury and respiratory illness in the Regional Health Plan are achieved – assuming regional agreement.
- A joint Waitemata DHB/Auckland DHB Child Health Improvement Plan implementation is agreed

Whanau Ora: The school-based health initiative will be measured by:

- 95% of participants are enrolled and engaged with a general practice
- 95% of children participating in the initiative are receiving oral health care
- 100% of Māori children and 95% whanau in the initiative, report increased knowledge and awareness of Rheumatic Fever through the development of Māori specific health education as well as demonstrating increased knowledge about the importance of hand hygiene in preventing skin infections

Oral Health

- Improved enrolment and preventative oral health care for pre-schoolers to meet Ministry of Health targets (appendix 1 and 3)
- Pre-school co-ordinators in place to access pre-school centres, kohanga reo and language nests

Breastfeeding

- Exclusive and full breastfeeding rate targets for 2012-13:

	Māori	Pacific	Total
6 weeks	74%	74%	74%
3 months	61%	61%	61%
6 months	29%	29%	29%

** note: we are working towards the achievement of these targets, aiming to close the gap between ethnicities in the medium term*

Collaboration

- Rheumatic Fever sore throat clinics are successfully implemented and operational
- Progress is made toward the following long term targets:
    - Rate of Rheumatic Fever is below 0.4/100,000 (by 2020) for all populations
    - Rheumatic Fever rates for Māori and Pacific children have decreased to the same level as other children (by 2020)

3.16 Youth Health

This is important for community and patients

More adolescents access dental services which means oral health improves. Inequity of access between Māori, Pacific and Others decreases. An acceptable approach to deliver school-based health services in Māori education settings will be developed to increase access to primary healthcare for Māori secondary students.

How are we going to do this?

Oral health

- Work with the Auckland Regional Dental Service on implementing the Ministry of Health approved Adolescent Utilisation Strategy with a particular focus on Māori and Pacific peoples

School based health services in Māori education settings

- Work with a secondary school in the Auckland DHB region to develop and pilot a whānau ora school-based health initiative that promotes and increases awareness of health initiatives relevant to youth and their whanau

Specific deliverables and measures

Oral health

- The percentage of adolescents of all ethnicities, including Māori and Pacific peoples, accessing dental services through contracted dentists increases to 77% for the 2012 calendar year and to 85% for the 2013 calendar year

School based health services in Māori education settings

- A Whanau Ora process is used to identify barriers during the pilot programme and solutions recommended at the conclusion of the pilot programme
- All students in the pilot programme are offered a HEADSS assessment and reasons for declines and outcomes from assessments are clearly documented within an evaluative framework

3.17 Pacific Health

This is important for community and patients

Increasing Pacific access to health care and quality of care will improve Pacific health outcomes and reduce health inequalities for Pacific peoples. Pacific people currently experience poorer health outcomes overall compared to others, particularly for Pacific men. Issues can occur in regards to Pacific people accessing health services and the care received once services are accessed. These differences should be eliminated.

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

How are we going to do this?

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

- A joint Pacific Action Plan to assist the process and alignment of collaborative health services across Auckland DHB and Waitemata DHB
- Work with PHOs, Parish Community Nursing and Healthy Village Action Zones' communities to protect and improve the health of Pacific people
- A review of projects common to both DHBs, such as Healthy Village Action Zones (HVAZ), Youth Action Committee (YAK) and Enua Ola programmes, to include and adopt effective elements of each wherever possible to achieve greater health outcomes for Pacific peoples
- Supported opportunities for Pacific peoples to participate in both the development and delivery of Pacific health improvement activity across all levels of the Auckland and Waitemata DHBs
- Collaborating with colleagues across the DHB to achieve the national health targets

Specific deliverables and measures

Development of a joint Auckland DHB and Waitemata DHB Pacific Action Plan to achieve DHB health targets for Pacific - by Quarter 1 2012-13

Establish and increase referral/assessment and throughput of Pacific 12 patients diagnosed with COPD, but have never accessed services, to the Auckland DHB Community Pulmonary Rehabilitation Pilot project's self-management education workshops

Pacific Best Practice education delivered to 400 DHB staff and staff of our partner agencies per year to increase mainstream responsiveness to Pacific peoples

Pacific Clinical Leadership development strategy adopted, supported and implemented across the regional DHBs. This will involve:

- Regional Pacific Nursing and Medical Leadership Network forums (3 per year) to introduce clinicians to career pathway and leadership development opportunities through existing and funded Pacific workforce programmes, such as ANIVA, Le Va Health Awards, Pasifika Medical Association, and Ministry of Health funded workforce programmes

- Developing Pacific staff networks to support current Pacific health workforce activities/initiatives, such as the Rangitahi programme

All Healthy Village Action Zones churches (50+) represented through Pacific Youth Advisory Committee and actively engaged with lifestyle change and Stop Weight Gain programmes

Mental health 101 workshops for young Pacific people: 4 workshops per annum with a minimum off 22 people at each workshop

3.18 Diversity and reducing inequities

This is important for community and patients

There are unacceptable differences in health status between different groups living in the Auckland DHB area and hence our focus on inequities throughout this document. Those living with most deprivation have poorer health, a shorter life expectancy and are more likely to be admitted to hospital with avoidable problems. Māori and Pacific communities are overrepresented in admissions to hospital (acute and elective) when compared to 'Others'. Our activities to re-dress inequities focus on Māori, Pacific peoples and new migrant/refugee communities.

How are we going to do this?

Culturally and Linguistically Diverse (CALD) populations

- Enhance the Culturally and Linguistically Diverse (CALD) cultural competency of the health and disability workforce
- Improve access for non-English speakers to Primary Health Organisation services and Primary Care Organisation services by providing Primary Health Interpreting Services

Specific deliverables and measures

Culturally and Linguistically Diverse (CALD) populations

- Increased uptake of CALD Cultural Competency training (online and face-to-face), averaging 40 enrolments per month
- Primary Health Interpreting Services service use increased by 20% (based on 2011-12 total use)

3.19 Disability

This is important for community and patients

Auckland DHB will improve the responsiveness of our behaviour, communication, and physical assets within the context of accessibility. Our activity over the year will focus on providing more employment opportunities for disabled people through the Mainstream Programme. We will progress improvement work in our telephone system, our website, our written communication templates for patients and our facility procurement, design and renovation. The National Health Passport will be implemented in a phased manner across Auckland DHB services and sites.

How are we going to do this?

- Auckland DHB will continue with the successful implementation of the Mainstream Programme
- Develop and implement a range of disability awareness education and training options with the aim of increasing staff responsiveness
- Improve access and communication with service users with a disability, and develop our services and facilities using the appropriate design principles
- Advocate for accessibility compliance in the Northern Region DHBs Enterprise Content Management Pilot Strategy
- Advocate for accessibility compliance in Waitemata and Counties Manukau District Health Boards' Web Content Delivery Strategy
- A feasibility study will be undertaken to expand current text communication
- Prioritise services and sites for rollout of the National Health Passport within Auckland DHB

Specific deliverables and measures

- Recruit 2 people to the Auckland DHB Mainstream Programme and report to the Disability Support Advisory Committee by 30 June 2013
- All new starters with the Auckland DHB complete online training for disability responsiveness, modelled off the Waitemata DHB Disability Awareness e-learning module , and reported to the Disability Support Advisory Committee by 30 June 2013
- Review the automated telephone system with regard to its use for people with disabilities by quarter four 2013
- Options for improving the automated telephone system reported to the Disability Support Advisory Committee by 30 June 2013
- Develop a baseline style guideline for all written communication such as letters, forms and pamphlets, and all forms of electronic communication, as project initiation for June 2013
- 6 staff will be identified as disability champions and complete the 2-day 'Barrier Free' Accredited Assessor training, with the aim of building our in-house capacity to address physical environment barriers

- New facilities work (procuring, designing or renovating) complies with universal design principles and involves the services of an accredited Barrier Free Advisor
- Use of the National Health Passport will be implemented in a prioritised and phased manner across Auckland DHB services by 30 June 2013

3.20 Women's Health

This is important for community and patients

Better, sooner more convenient health services for mothers, babies and children and their families means that families do not have to navigate multiple systems in order to access the services they need. In particular, earlier booking with a Lead Maternity Carer facilitates access to a range of screening, early intervention and health promotion opportunities which benefit both mother and baby. Improved service integration helps families access the services they need, when they need them, resulting in improved maternal and longer term health outcomes for children growing up in New Zealand. The quality and safety of maternity services is assured and the right level of care is provided to all pregnant women and their families.

How are we going to do this?

Maternity Services

- Implement the Maternity Quality and Safety Programme
- Implement the new Auckland DHB Maternity Strategy that includes:
    - Communicating to general practices that more Lead Maternity Carer midwives are available to provide continuity of care at Birthcare, the primary birthing facility in Auckland District Health Board
    - Making better use of co-located National Women's Health community midwives in general practices in high need areas
    - Aligning the pregnancy and parenting education service delivery model with the revised service specification so that the reach and acceptability of services to vulnerable, teen and first time parents are increased
    - Exploring options for engaging social workers to work alongside teen parents and vulnerable pregnant women from pregnancy, through the first year of a child's life and until such time as the family and whanau are confident to parent and navigate services without additional support

Women's Health

- Improve the coordination of and women's access to cervical screening services in primary care with a focus on Māori by implementing an Auckland Metro Cervical Cancer Coordination Service
- Jointly with the Cancer Healthcare Service Group, monitor equity of access to breast screening services, in particular for Māori, and recommend service improvements to the Ministry of Health and their providers

Specific deliverables and measures

Maternity Services

- The Auckland DHB Maternity Quality and Safety Programme Strategic Plan is signed off by the Ministry of Health, and implemented from July 2012
- The new Auckland DHB Maternity Strategy establishes clear pathways for all pregnant women, taking into consideration their social and clinical needs
- The new Women's Health Clinical Governance Structure is embedded and takes responsibility for clinical issues at the right level
- Auckland DHB's performance against the new national maternity indicators is examined, an analysis undertaken of any areas where Auckland DHB is an outlier, and remedies are identified, implemented and monitored by the Maternity Clinical Governance Group
- The number of primary births managed by Birthcare Lead Maternity Carers increases from 450 to at least 600, by 30 June 2013
- Midwives are currently co-located in 7 GP practices in the west and 5 in the east. Communication between these GPs and Midwives is enhanced through the implementation of the shared record of care
- Current services are better aligned to improve outcomes for teen and vulnerable pregnant women. This is achieved by connecting women, their families and services from pregnancy through the first years of their infant's life through a dedicated social worker and/or health worker. Recommendations from this process are implemented from 2013-2014
- Progress towards 90% of all pregnant women who identify as smokers are offered advice and support to quit through collaboration with National Hauora Coalition and PHOs (Northern Region Health Plan target)

Women's Health

- The proportion of medical to surgical terminations of pregnancy increases
- Improved National Cervical Screening Programme coverage rate against targets of:

	Dec 2011	2012/13
Total	73%	75%
Māori	53%	75%
Pacific	73%	75%
Asian	55%	75%

NB. removing current inequities between ethnic groups is acknowledged to take several years, however we commit to working towards achieving equity

- Improved Breast Screen Aotearoa coverage rates against targets of:

	Sept 2011	2012/13
Total	66.2%	80%
Māori	64.7%	80%
Pacific	79.9%	80%

NB. removing current inequities between ethnic groups is acknowledged to take several years, however we commit to working towards achieving equity

3.21 Clinical/Change Leadership

This is important for community and patients

Auckland DHB is making clinical leadership a cornerstone of our development. To strengthen clinical leadership at the senior levels of our organisation we have a coordinated set of activity for the year. This involves supporting our clinical leaders and managers to be more effective at taking action within our management operating system, implementing our clinical leadership model and programme, and rolling out a talent identification and development programme for future clinical leaders. The clinical leadership programme is strongly aligned to patient safety and improving the patient and family experience.

We will also support expanded activities of the regional training hub, inclusive of nursing/midwifery and allied health, scientific and technical professions, continue our support for the implementation of career plans for House Officers, support professional competency development for Resident Medical Officers and Senior Medical Officers, and implement regionally consistent education and training resources. All regional and national clinical networks will have Auckland DHB members. Clinical leadership is essential for clinical service innovation and sustainability.

How are we going to do this?

- Develop and implement a leadership programme for clinical leaders, senior managers and emerging leaders, with a special focus on Māori and Pacific staff
- Support the professional development of Resident Medical Officers (RMO), focusing on the CanMEDS competency framework, and improve the RMO work experience by establishing regional and local engagement groups
- Support the development of, and provide leadership to, regional/national multidisciplinary clinical networks, inclusive of whole of sector participation

Specific deliverables and measures

- 80% of Māori and Pacific leaders at levels 2, 3 and 4 complete components of leadership development training
- 60% of level 2 and 3 leaders of other ethnicities complete components of the leadership development training
- Young talent, including Resident Medical Officers, identified and engaged in leadership development
- Run satisfaction scores at 3.5 or better for every RMO rotation
- Auckland DHB clinicians participate in clinical networks as agreed in the Northern Regional Health Plan and/or National Services

3.22 Workforce

This is important for community and patients

An important focus for 2012-13 is engagement of staff in the organisation's goals. Engaged staff are more productive, more patient- and family-focussed and more likely to remain within the organisation. Our staff survey will inform what more we need to do to lift engagement levels.

Our workforce strategy will help us improve the quality and quantity of information and research available to collect, standardise and analyse the data we need to show current and project future workforce profiles and requirements. This will inform workforce innovation and redesign.

We will also improve our succession planning, and identify barriers and enablers to staff working at 'top of scope'. Our activity will align to regional initiatives, services changes and consider HWNZ service forecasts. We will expand workforce development and career pathways for Māori and Pacific peoples.

How are we going to do this?

Culture

- Complete staff engagement survey tool as part of Health Care Excellence
- Identify and develop future leadership talent by implementing succession planning framework

Employment Relations

- Increase employee engagement in organisational changes and developments
- Good Employer obligations met

Capability

- Implement NoRTH (regional training hub) mandatory requirements
- Establish the workforce requirements for new models of integrated care and identify barriers and enablers to working at 'top of scope'

Capacity

- Expand current workforce development programmes for Māori and Pacific
- Engage with tertiary education providers to influence curriculum design and drive innovative workforce development

Workforce Intelligence

- Standardisation of workforce data collection and metrics across the region
- Improve the quality and quantity of information and research available to improve workforce planning and forecasting to inform workforce innovation and redesign

Specific deliverables and measures

State Services Commission requirements

- Clinical leadership appointments (level 2 and 3 roles) and development as outlined above

Culture

- Translate findings from engagement survey into strategies that can be implemented to improve staff culture and productivity

Employment Relations

- Engagement through bipartite discussions with key health unions

Capability

- Implement Whanau Ora workforce initiative
- Expand nurse prescribing pilots pending results of Auckland DHB diabetes nurse prescriber evaluation
- Implement cohort 2 of the Registered Nurse First Surgical Assistant Pilot
- Implement employer-led training programme for Allied health therapy assistance Level 3 NZQA qualification
- Nurse Practitioners able to enrol patients into PHOs and be eligible for capitation

Capacity

- 20 new Māori and Pacific graduates appointed per year
- 20 Māori and Pacific cadet (work experience) placements per year
- Roll the web-based system for booking and scheduling clinical placements for students out across the northern region

Workforce Intelligence

- Agreement of northern regional workforce data metrics including:-ethnicity data, turnover (voluntary), leave (annual and sick), demographics, vacancies and budget, by December 2012

3.23 Patient and Family / Whanau Experience

This is important for community and patients

Our DHB will do more to make patient safety and the patient and family (Whanau) experience key strategic goals. Our Health Excellence Framework already has patients and community at the centre point of all quality improvement work. The Northern Regional Health Plan and the Memorandum of Understanding with the Health Quality and Safety Commission also demonstrate our commitment around patient safety, with feasible goals set along with a real expectation of better patient outcomes.

We need to respectfully acknowledge the value that families can bring in supporting patients in our hospitals and residential facilities. To ensure patients get this social support when they most need it we need to open the doors and welcome family; not as visitors, but as key enablers of the patient's recovery to former health status. Respect is a key value for this organisation. Respecting the family's need for information, to be present at the bedside, and to have a role in supporting care is something we will achieve through a programme of work which includes: the Bereavement Project, Family are not Visitors project, Improved Responsiveness to Complaints, and Advanced Care Planning, among a wide range of other service planning and improvement initiatives.

How are we going to do this?

Open Disclosure

- Provide more training to our clinician leaders so they openly disclose when things go wrong

Family as Partners in Care

- Translate the concept of 'Families are not Visitors' into reality by building the case for a change in culture

First Do No harm

- We will understand how many patients fall and why they fall in our facilities in order to make changes to reduce harm
- We will do the same for patients affected by pressure injury
- Central Line Acquired Bacteriaemia: We will reduce blood stream infections by using standardised protocols for central line insertion and maintenance

Reducing time to serious complaints resolution

- We will reduce the time it takes to resolve serious complaints

Bereavement Project

- Our bereavement service will be implemented

Advance Care Planning

- Our staff will be trained to have discussions around advanced care planning

Patient Experience Survey

- We will make it easier for patients and families to give feedback on our services

Specific deliverables and measures (in support of our region's health plan)

Open Disclosure

- 50% of Level 2 and 30% of Level 3 leaders will complete the training by June 2013

Family as Partners in Care

- Business case approved by December 2012
- Programme roll-out has begun by June 2013

First do no harm

Pressure Injuries and Falls

- A method to improve measurement of falls with harm and pressure injuries by end of quarter one
- Falls risk assessment and intervention plans are standardised for adult inpatient units by end of quarter one
- All facilities, including each ward of the inpatient secondary service are audited monthly for pressure injuries by end of quarter one
- Audit of single day pressure injuries in Aged Residential Care facilities to inform baseline by the end of quarter three
- Stocktake of reporting tools and intervention strategies for falls with harm and pressure injuries in Aged Residential Care facilities
- Pressure injury risk assessment and intervention plans are standardised across inpatient units by end of quarter one

Central Line Acquired Bacteriaemia

- 40% reduction in Central Line Acquired Bacteriaemia in intensive care units

Reducing time to serious complaints resolution

- A face-to-face meeting with 100% of consumers with serious complaints is held within 2 weeks
- 100% of serious complaints are resolved within 20 working days

Bereavement Project

- Bereavement Service implemented by June 2013

Advance Care Planning

- Training packages are completed by 2013
- At least 175 patients have documented evidence of Advance Care Planning discussions

Patient Experience Survey

- The communication campaign is rolled-out by December 2012
- The process and outcomes of the real-time patient experience feedback trial is evaluated by 2013

3.24 Living within Our Means

This is important for community and patients

Auckland DHB must be a sustainable organisation that manages its financial health without deficits and continues to live within its means. We will deliver our services and perform our functions efficiently. This requires tight cost control to limit the rate of cost growth pressure, purchasing and productivity improvement to deliver services more efficiently and effectively across both NGO and hospital providers, and service reconfiguration to support improved national, regional and local service delivery models, including greater regional cooperation.

How are we going to do this?

Production Planning

- A production plan that reflects the needs of the population and the services required by other District Health Boards, matched against the available capacity and funding

Resource Planning

- Resources are prioritised to align to the organisation's key goals and targets

Asset Management Planning

- An asset management plan provides the long term context for the organisation's investment in assets that is aligned to service delivery needs and affordability

Collaboration

- Collaboration will occur at a national and regional level including regional planning and participation in national and regional shared services

Performance Improvement

- Initiatives are identified and implemented to deliver improved productivity, efficiency and effectiveness

Specific deliverables and measures

- The operating budget is achieved – no deficits
- Shared service agencies, nationally and regionally, deliver their specified benefits, including costs savings and added value from procurement and other initiatives
- Financial covenants are not breached
- The asset management plan is updated and submitted to Crown Agencies within the required timeframe

MODULE 4: Stewardship

This section concentrates on those activities (enablers) that help us manage the organisation: Workforce development, information systems, and clinical leadership. These all support our front-line services and contribute to better services for our patients and communities. The priority health goals and service delivery objectives covered in modules 2, 3 and 5 cannot be delivered without considerable and constant development of infrastructure.

As both funder and provider of health services, we must operate in a financially responsible manner and be accountable for the assets we own and manage. We must also ensure that every public dollar spent, is spent with the intention of improving, promoting and protecting the health of our population.

4.1 Strengthening our Workforce

Organisational Health

Auckland DHB aims to be a good employer and is aware of its legal and ethical obligations in this regard. Auckland DHB aims: *"To recruit, develop and maintain a sustainable, responsive, collaborative and skilled health and disability workforce focused on the health needs of the population of ADHB, now and into the future".*

Auckland DHB operates Human Resources policies containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment. We will seek to actively uphold any legislative requirements in this regard, and will put in place such systems and programmes to support this principle.

Auckland DHB has a true commitment to its employees and its services. Regardless of the minimum requirements of legislation, Auckland DHB will continue to promote and protect the welfare and management of employees to the mutual benefit of employees, patients and the organisation.

We will provide equal employment opportunities by eliminating any barrier that may deny a potential or existing employee the opportunity to be equitably considered for employment of their choice. The chance to perform to their maximum, is a key principle practised by all representatives of Auckland DHB in the execution of activities relating to the recruitment and management of employees (or potential employees). This includes:

- Recruitment
- Pay, recognition and other rewards

- Career development
- Work conditions

Auckland DHB's Human Resources policies and practices will be free from any discriminatory element that has the potential to deny a person equal opportunity.

Auckland DHB will:

- 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 Auckland DHB's "Values" and the State Services Commission "Code of Conduct"
- provide a healthy and safe workplace, equipment and conditions
- provide recruitment, selection and induction processes that recognise the employment requirements of women, men and persons with disabilities
- recognise the aims, aspirations and employment requirements of Māori people
- take measures to ensure that qualified Māori candidates are given every opportunity for employment
- Auckland DHB may adopt special measures to ensure Māori representation and participation at Auckland DHB
- recognise the aims, aspirations and employment requirements of Pacific Island people
- take measures to ensure that qualified Pacific Island candidates are given every opportunity for employment
- Auckland DHB may adopt special measures to ensure Pacific Island representation and participation at Auckland DHB
- recognise the aims, aspirations, cultural differences and employment requirements of people from other ethnic and minority groups
- provide opportunities for individual employee development and career advancement

Our workforce development strategy

The Auckland DHB Workforce Strategy 2012-2016 covers the four components of the framework provided by the State Services Commission: culture, change leadership, capability and capacity.

Engaged Workforce (Culture)	We will improve staff engagement. A sense of purpose and focussed energy makes staff more productive, more patient-focussed and more likely to remain within the organisation. An engaged workforce is more adaptable and can be deployed more readily. We will implement a staff engagement survey.
Change Leadership	Clinical leadership helps to achieve better outcomes for patients and service sustainability. We will: • Develop and implement a leadership programme for clinical leaders and senior managers

	• Support the development of, and provide leadership, to implement regional/national multidisciplinary clinical networks
Capability	We will develop new roles and team structures that increase productivity, or the enhancing of scopes of practice, to enable clinicians to use their specialist knowledge and skills in ways that enable the DHB to meet future demand. We will: • Implement NoRTH regional training hub requirements • Establish the workforce requirements for new models of integrated care • Facilitate workforce innovation and new/expanded roles • Identify barriers to health care professionals working at the `top of their scope' and develop strategies to mitigate
Capacity	We will develop a workforce that reflects the communities Auckland DHB serves. We need to recruit from the local community. We are committed to Te Tiriti O Waitangi and acknowledge Māori as our partners in delivering sustainable health services. We will: • Expand current workforce development programmes for Māori and Pacific • Implement strategies to recruit and retain critical/vulnerable workforces • Engage with tertiary and training providers • Market and promote health careers to high school leavers

NoRTH

Auckland DHB is using the regional training hub to engage collaboratively with other DHBs on workforce matters. The Northern Region Training Hub (NoRTH) provides support to post graduate medical, nursing and allied health trainees. This builds on the work previously undertaken for the Auckland metropolitan DHBs for Resident Medical Officers by ARRMOS. NoRTH will:

- Strengthen existing RMO clinical and managerial oversight to include active participation from medical, nursing and allied health professions and all four DHBs
- Lead key elements of workforce training and development for professional groups, with an initial focus being on Resident Medical Officers (particularly 2nd year house officers) and specialist nursing and allied health roles
- Align recruitment, workforce planning and development to support delivery of new models of care and delivery of the Northern Region Health Plan
- Strengthen systems and processes to support placement and workforce development activity

Workforce Data Intelligence

Overarching principles of Health Workforce NZ have been used to identify our workforce needs and gaps. We use workforce data to help us plan for future workforce needs. Data analysis focuses on recruitment, retention, age, ethnicity and gender profiles. This approach will help us close the gaps and ensure a sustainable and appropriate workforce for the future.

We will work with regional DHBs to collaborate on workforce data, collection, forecasting future workforce requirements and workforce metrics. We will:

- Standardise data collection, forecasting and metrics
- Collect and analyse data to inform workforce forecasting for service planning
- Provide workforce forecasts and projections for Auckland DHB

Clinical Leadership

Clinical leadership means clinical staff engaged in organisational decision-making, workforce planning and professional development, and in day-to-day leadership of teams providing clinical services. This achieves a sustainable health workforce, and a workplace culture that is innovative, attracts and retains staff. Ultimately clinical leadership will help to build a more unified health system where clinicians work together with patients (and their carers/families) to establish patient needs and improve health outcomes for them. Clinical leadership also improves job satisfaction for clinicians by increasing their participation in decision-making.

The focus for the future is on new models of care and workforce innovation:

- better support the development of a more generic workforce
- improve recruitment and retention
- enable health professionals to take on new tasks and responsibilities
- ensure effective workforce linkages
- enable regional alignment and planning
- make the best use of training settings.

Further detail is covered in our Workforce Strategy 2012-2016.

4.2 Regional Information Systems

Information systems enable the Northern Region to deliver a whole of system approach to health service delivery. We will improve the continuity of care for patients in our region across primary, secondary and tertiary care by making sure that clinicians have consistent and reliable access to core clinical information.

The Northern Region's shared services support agency, healthAlliance NZ Ltd, will work with the region's four DHBs to bring clinical teams together around the patient, and to support improved clinical workflows, safety and decision-making across the sector. The following projects will take several years to achieve.

Single patient administration system	The region will develop a common patient administration system, with standardised processes and improved data quality related to: • patient registration (NHI, demographics) • administration of patients through our facilities (referring, scheduling,

	booking, administration, transfer and discharge) Primary care requires improved access and contribution to National Health Index (NHI), demographics and visit information. Seamless integration with primary care patient management systems are required to support primary care access to the regional clinical workstation and the proposed regional clinical data repository
Single Clinical Workstation	The region will progressively standardise on a single clinical workstation. This will provide a consistent user experience, improve clinical communication and reduce the complexity of integration and audit functions. The regional project links to the national initiative to standardise the clinical workstation
Regional Clinical Data Repository	To achieve continuity of care, a regional clinical data repository is required. Northland DHB is the next to join the Regional TestSafe system which will see Northland clinicians accessing and contributing to the regional clinical repository. Improved primary care access and contribution to TestSafe is an additional objective
Population Health Data Repository	There will be a single source for regional population health information, potentially supported by a shared population health team. This will improve collection, quality, availability and sharing of population health data across DHBs and PHOs
Electronic solutions to support Safe Medication Management	Regional work supports the national eMedicines programme and will include: • the roll-out of medicine reconciliation for secondary care • a pilot for hospital ePrescribing
Shared Care Plan	New models of care depend on multidisciplinary teams working across primary, community and secondary care, and together with the patient A patient-centred clinical management system promotes integrated care, acute demand management and the empowerment of patients The profile of this regional initiative will be raised following the pilot and will be scaled to support regional health improvement targets
Information Systems Infrastructure Resilience	The resilience of core IS infrastructure in all four DHBs must be reinforced to maintain capability and support ongoing development

Activities in 2012-13 that support the Northern Region Health Plan:

- Implement 'Acute Predict' for consistent cardiovascular disease and diabetes risk assessment
- Identify information system gaps re cardiovascular disease and diabetes initiatives
- Implement information systems to support the 'Access to Diagnostics' initiative
- Feasibility and scoping of systems to support Advance Care Planning.

Additional investment may be possible in other regional projects, such as:

- Shared financial management systems
- Content Management
- eReferrals

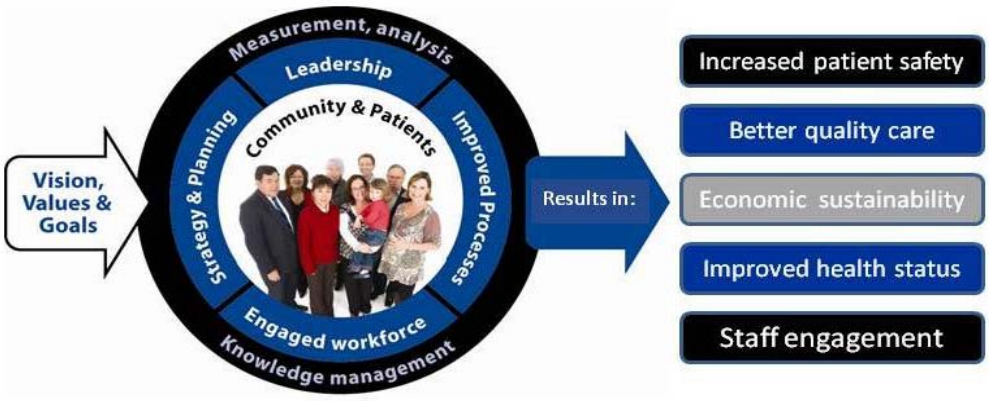
- eDischarges (implemented to national standards)
- eRostering
- Continuation of regional network integration, single sign-on and single service desk as part of the shared service programme of work
- IS support for the Better, Sooner, More Convenient business case workstream.

Further detail is available in the Northern Regional Information Strategy 2010 to 2020, and in the Northern Region Information Systems Implementation Plan.

4.3 Managing our Organisation

Managing Performance

Healthcare Excellence is our community and patient-centric performance improvement framework. It connects our vision, goals, mission and values to the development of our organisation's culture, capability and processes so that we deliver superior results now and into the future. There are five key result areas that we organise our work activities around: patient safety, quality, health status, staff engagement and economic sustainability.



Healthcare excellence: Our Performance Improvement Framework

We want to provide the best healthcare in New Zealand and to also be the best healthcare provider to work for. The Healthcare excellence framework is our commitment to continuous improvement – building on existing strengths to be the best we can be today while searching for better ways of working.

We can always do better for our community and patients. There are inefficient processes and problems that must be addressed as part of our performance improvement programme of work:

- there are still too many adverse events that cause harm
- our services aren't always designed with patients and their families at the forefront
- we have unacceptable disparities in health status between groups in our community
- we haven't fully engaged all our staff in improving the performance of our organisation

We also have to manage with a reduced growth in funding. We will need to be more innovative in how we deliver services.

The Health Quality and Safety Commission will help by resolving what are sector-wide problems; particularly in improving medication safety and increasing the percentage of patients who receive medicine reconciliation.

Provider Interests

Auckland DHB Charitable Trust (A+ Trust) is 100% owned by Auckland DHB. Auckland DHB has no plans to acquire shares or interests in any company, trusts and/or partnerships, other than the proposal to establish the new northern shared services organisation. Auckland DHB is a shareholder in healthAlliance N.Z. Limited.

An Annual Report is prepared at the end of the financial year. There are also regular reporting requirements as outlined below.

- Information requests, Ad hoc
- Financial reporting, Monthly
- National data collections, Monthly
- Risk reporting, Quarterly
- Crown Funding Agreement non-financial reporting and Indicators of DHB performance, Quarterly
- Hospital Benchmarking Information, Quarterly

Health Benefits Limited

Health Benefits Limited is a crown-owned company, established in 2010 to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Using a commercial model, Health Benefits Limited works for all DHBs, to reduce the cost of shared services, as well as leading initiatives that make savings. Savings are reinvested in clinical areas.

Auckland DHB supports this national work and understands that national work may result in changes to our local processes, systems, functions and ultimately positions.

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

- reducing costs

- achieving operational efficiencies in administration, procurement and support services
- sharing good practice in administration, procurement and support services

Collective procurement	Clinical Advisory Groups are assigned to specific projects, a number of which go to market in 2012-13 as Requests for Proposals
Finance	A Case for Change has been released with work underway to confirm the high level processes required within a national system. The first draft of individual DHB business cases is expected by the start of the 2012-13 year.
Supply chain	Supplier site visits have been undertaken with design workshops underway. Health Benefits Limited is analysing the information provided by DHBs and will work with DHBs to produce detailed current state information.
Facilities management and support services	Health Benefits Limited and DHBs will work to align work. Priorities are food, laundry and facilities. Others include waste removal and reviewing fleet and parking arrangements. Health Benefits Limited may use an Expression of Interest process to find the best options. All work in this area, including procurement processes or investing in significant assets – within the scope of this programme, will be carried out in collaboration with Health Benefits Limited and will not preclude national design options. DHB experts will be involved in feasibility studies to develop options for delivering services. The Indicative Case for Change will be released in the first half of 2012.
Information Services	Health Benefits Limited is establishing the IS programme advisory groups to ensure Health Benefits Limited receives the right input and guidance, both for technical and commercial considerations. A coordinated approach to short and longer term national infrastructure will result in significant collaborative, financial and operational benefits for `back office' IT. A Request for Information has been issued, followed by an evaluation of service delivery options to determine the shape of national infrastructure. 2012-13 activities: • complete an evaluation of the options available for national infrastructure service delivery • identify the right model for national infrastructure for the health sector • plan the technology and commercial roadmap that will define the transition from today to that model. IS Procurement – Vendor Consolidation: Health Benefits Limited is working with DHBs on consolidation opportunities – ensuring cross-DHB or national licenses meet the needs of the sector. National contracts for video conferencing will be released to the sector by the start of the 2012-13 year. Website www.itcontracts.health.nz is active, providing MSA standard document templates online for download and use.
Human resources **Workforce management**	The HR/Workforce Programme will identify an HR information system that can be rolled out nationally. The first stage is to agree the business requirements, functional requirements and high-level processes that DHBs expect to be supported by the system. Health Benefits Limited and DHBs will identify best practice and a national standard in these areas. This will support the system(s) being rolled out in a

	consistent manner and allow training, process documentation and best practice to be shared across DHBs. Auckland DHB staff will be involved in workshops to agree requirements and design processes.

4.4 Quality and Safety

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

Auckland DHB risk management includes:

- Reducing risk to patients through the "First Do No Harm" regional project
- Leading the national hand hygiene programme to reduce hospital acquired infections
- Participating in the development of a consistent national approach to monitoring and reporting on surgical site infections leading to reduced surgical site infections
- Developing and commissioning a review of a risk management framework that identifies failures within key organisation systems and process
- Using the failure mode effective analyses approach, provide a mechanism that links with improvement projects within the DHB.

Quality assurance and improvement
Review and implement a quality assurance monitoring program within Auckland DHB by developing a suite of data bases for capturing, monitoring and reporting of quality assurance activity.

4.5 Reporting and Consultation

The DHB must include the range of matters the DHB must consult / notify the responsible minister of before making a decision and those on which it will report to the Minister and frequency of reporting. We will consult with the Minister, via the Ministry of Health, on any significant developments during the financial year that are not signalled in this plan.

4.6 Other Agreements and Arrangements

In this 2012-13 Annual Plan, Auckland DHB signals our intention to enter into collaborative agreements, including alliance contracts, with other organisations to implement local, regional, and national plans. This results in effective and efficient health service delivery or activities that

are consistent with the government strategy: 'better, sooner, more convenient'. Auckland DHB may also enter into co-operative agreements or arrangements in order to:

- Meet public health objectives for the region
- Improve public health outcomes for Māori across the region
- Advance the healthy housing development strategy
- Work regionally and nationally with other DHBs, DHBNZ, tertiary education institutions and the Crown in respect to health education and workforce development
- Work regionally and nationally with other DHBs and DHBNZ in relation to procurement
- Achieve regional collaboration in the recruitment of staff
- Maintain the multi-agency centre, Puawaitahi, where various agencies case-manage specialist investigation and treatment for abused children
- Allow staff of other entities to access Auckland DHB facilities for research, training or to work with Auckland DHB staff
- Undertake initiatives with tertiary education institutions to promote public health, research, evidence-based practice and clinical effectiveness
- Undertake clinical trial agreements, via the ADHB Charitable Trust to develop better treatment options and quality measures
- Enable Auckland DHB to assist ACC in the treatment of injuries and provision of care
- Obtain occupation licences to allow early childhood education and care services on Auckland DHB sites for children of Auckland DHB staff
- Obtain occupation licences to provide premises for organisations who assist Auckland DHB in meeting its objectives or to enhance health or disability outcomes for people, for example Starship Foundation and Ronald McDonald House
- Assist with the treatment of inmates in the care of the Department of Corrections
- Support community health initiatives
- Implement a regional Drinking Water Incident Co operation Plan
- Co ordinate with other sectors in Strengthening Families, the joint sector project to improve case management for children and families with high need

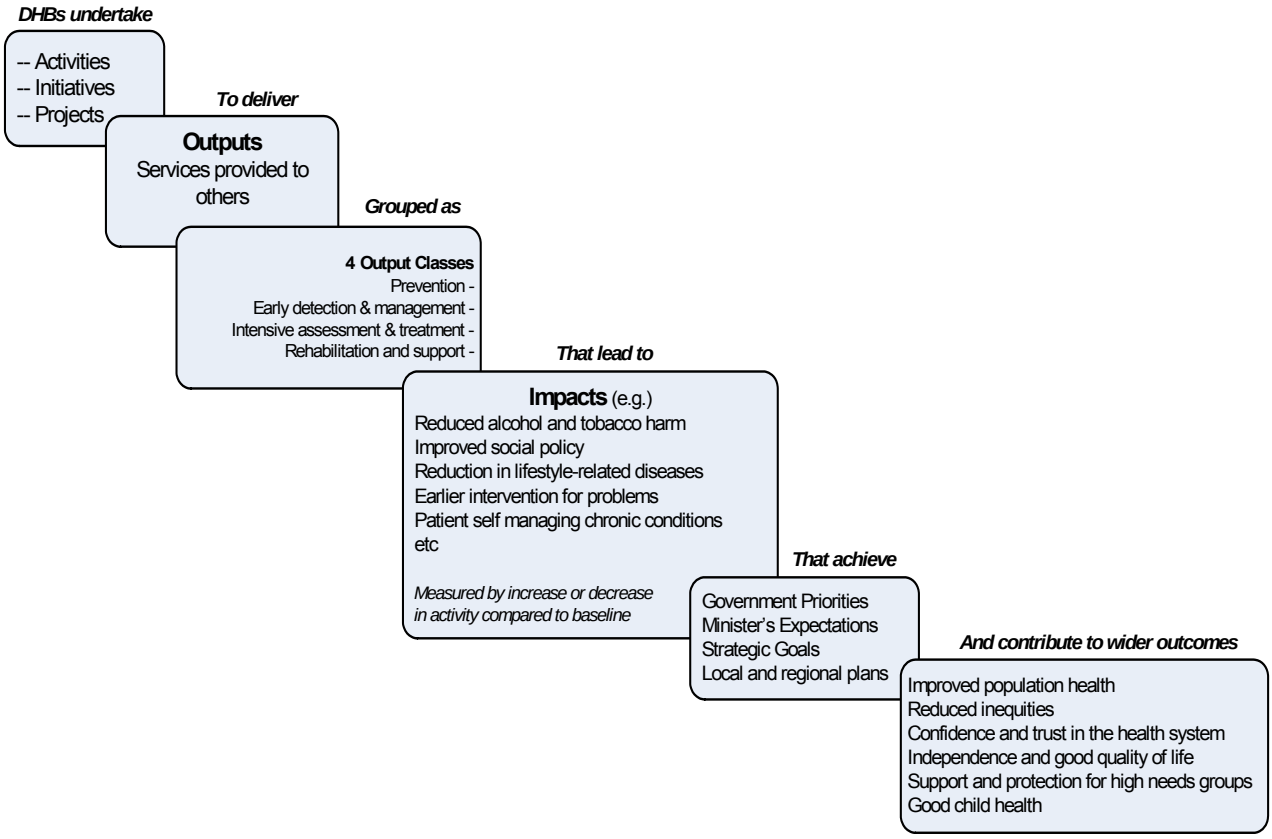
The finalisation of this plan authorises and permits Auckland DHB to enter into co-operative agreements, service agreements or other arrangements required to achieve the strategic objectives and outcomes outlined in this Annual Plan or to deliver the services Auckland DHB is required to deliver. The terms and conditions of those co-operative agreements or arrangements will be as Auckland DHB considers appropriate for the particular services contracted for in that service agreement (Sections 24 and 25 of the New Zealand Public Health and Disability Act).

MODULE 5: Forecast Service Performance

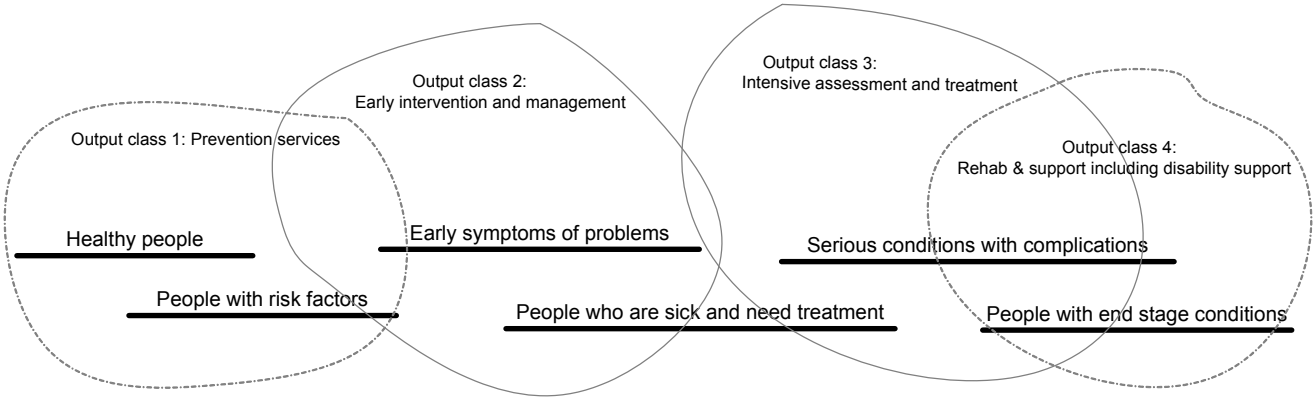
The Forecast Statement of Service Performance identifies outputs, measures, and performance targets for the 2012-13 year. Recent actual performance data is used as the baseline for targets. Auckland and Waitemata DHBs use only a few cornerstone measures here to cover what is a vast scope of business as usual activity. Those included here provide a reasonable representation of the services provided by a District Health Board.

Measures within this Statement of Forecast Performance are defined as outputs – being those activities we do to deliver our goals and objectives in modules 2 and 3. Measures are concerned with the quantity, quality and the timeliness of service delivery. The level of funding associated with each output class is contained in the financial section. There is background, baseline measures and targets for these output areas in Appendix 5.

The Statement of Forecast Service Performance fulfils the requirements of section 139 of the Crown Entities Act 2004 and sections 39 and 42 of the NZ Public Health and Disability Act 2000. The Auditor General will audit the accuracy and reasonableness of the DHB's service performance when these are reported in our Annual Report.



The intervention logic that underpins this Statement of Forecast Service Performance



DHB activities fall loosely into four output classes

5.1 Output Class 1: Prevention Services

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. This output class comprises a few cornerstone services which enhance the health status of the population (as distinct from treatment services which repair/support health and disability dysfunction). Those few services included in this section provide a reasonable representation of the type of prevention activity in our region.

These services address individual behaviours by focusing on population-wide physical and social environments to influence health and wellbeing.

On the continuum of care, prevention services are public-wide e.g. population health focused. Services 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.

It is important to note, that while there are disparities in health service access and health status between ethnic groups, the health sector does not set differential targets for different ethnic groups. We have an expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity.

Outputs include:

- Alcohol and tobacco regulatory activities
- Health protection
- Health Policy / Legislation Advocacy and Advice
- Health promotion
- Population Based Screening

We undertake initiatives & activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Health Protection: Communicable disease surveillance and control activities	Investigation and control measures	**Quantity** Number of outbreaks investigated Number of contacts traced **Quality** Communicable disease protocols up-to-date Communicable disease protocols adhered to	Population health protected by reducing secondary cases	Number of outbreaks investigated
Health Protection: Environmental control activities including: air quality; border health protection; burial and cremation; contaminated land; water quality; hazardous substances; radiation; sewage; waste management; resource management.	Surveillance, investigation and control of hazards	**Quantity** Number of investigations in relation to built environments **Quality** Proportion of Hazardous Substances and New Organisms events responded to appropriately **Timeliness** Proportion of Public Health Risk Management Plan (PHRMPs) Reports submitted to the water supplier within 20 working days	Reduction in adverse effects of environmental hazards	Number of environmental hazards detected
Health Protection: Emergency planning and response	Emergency plans Emergency responses	**Quantity** Number of emergency response exercises participated in Number of emergencies responded to **Quality** Emergency Plan up-to-date **Timeliness** Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border	Rapid and effective emergency responses	Evaluation reports and inquiries into emergency responses to show adherence to best practice

We undertake initiatives & activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Health Promotion: Monitoring compliance with smoke free and alcohol sales legislation	Monitoring and enforcement of liquor and tobacco premises	**Quantity** Number of liquor licence applications processed by the Auckland Regional Public Health Service, and all problematic premises that receive a compliance check **Quality** Alcohol compliance protocols are adhered to when site visits are carried out **Timeliness** Liquor licensing applications processed within 15 days Tobacco complaints responded to within 5 days	Reduced sales of cigarettes and alcohol to youth and minors, safer drinking environments and smokefree environments	Proportion of controlled purchase operations in which alcohol or tobacco product sales are sold to minors
Health Policy / Legislation Advocacy and Advice: Analysis and comment on health policy proposals and draft legislation with implications for public health	Submissions on health policies, regulations and legislation	**Quantity** Numbers of submissions made **Quality** Submissions policy adhered to **Timeliness** Submission documents submitted by deadline	A national policy, regulatory and legislative framework favouring improved and more equitable health	Changes in draft legislation / regulation / policy made in response to submissions
Newborn Hearing Screening: Newborn hearing screening for all babies born in Auckland DHB	Newborn hearing screening checks Diagnostic audiology services Aided hearing	**Quantity** Number/proportion of babies screened **Quality** Referral rate to audiology <=4% **Timeliness** Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme	Age appropriate language, learning and social development	Hearing loss is identified by 12 weeks of age for >=95% of children referred to audiology by the screening programme

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 carried out in Primary Care is preventive in nature.

This activity contributes to longer term outcomes:

- Reduction in alcohol and tobacco related harm including smoking-related chronic diseases
- Reduced admissions of children to hospital with a problem linked to exposure to tobacco smoke
- Increasing smokefree environments and people
- Improve social policy
- Confidence and trust in the health system

5.2 Output Class 2: Early Detection and Management

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

Early detection and management services provide interventions that prevent problems at the earliest stage and offer help to stop problems becoming worse. By nature these services are delivered to groups, e.g. high risk groups, and also to individuals.

Outputs that relate to this class of activity include:

- Community Referred Testing and Diagnostics
- Oral Health
- Primary Healthcare
- Pharmacy

In terms of outcomes, good access to early detection and management services for all population groups, reduces disparities and improves population health. These services enable patients to maintain their functional independence while preventing relapse of illness.

Patient experience is improved through timely access to services, reassurance in the case of negative results, and prompt management of complaints and incidents. Clinical audits of services also help patients and their families / whanau have confidence in the health system. Effective early detection and management of patients reduces demand for more costly secondary and tertiary care services. This can also contribute to lower total expenditure on pharmaceuticals.

We undertake initiatives & activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Community Referred Testing & Diagnostics: Purchase and monitor community referred testing and diagnostic services	Community based laboratory tests and other diagnostics services	**Quantity** Number of community laboratory tests by provider Number of radiological procedures referred by GPs to hospital	Prompt diagnosis of acute and chronic conditions Patient reassurance in the case of	% of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing

We undertake initiatives & activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
including: – laboratory tests – radiological services for: cardiology, orthopaedics, neurology, audiology, endocrinology, respiratory – pacemaker physiology tests – ante-natal screening		**Quality** Complaints as percentage of total no. of laboratory tests **Timeliness** Average waiting time in minutes for a sample of patients attending Auckland DHB collection centres between 7am and 11am (peak collection time) 75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013	negative results Reduced demand on specialist outpatient appointments	absolute CVD risk in the last five years
Oral health: Fund and/or provide a range of services for the metro Auckland region that promote, improve, maintain and restore good oral health including: Health promotion activities targeting children and adolescents living in disadvantaged areas. Particularly Māori and Pacific Oral health examination and oral health education provided to preschool children & their parents	Oral Health education Oral examinations and treatment among preschool children, school children, and adolescents	**Quantity** Enrolment rates in children under 5 years Utilisation rates for adolescents (PP-12) Number of visits of preschool, and school children to oral health services (including adolescents) **Quality** Number of complaints in the financial year **Timeliness** Arrears rate by ethnicity (Māori, Pacific, Other, Overall)	Caries among children and adolescents is prevented, detected early and treated before major damage to teeth occurs Improvement of overall oral health with the reduction of inequalities among different ethnic groups	Percentage of children caries free and average Decayed; Missing and Filled Teeth of year 8 children by ethnic group Percentage of children caries free and average decayed, missing and filled Teeth of 5-year-old children by ethnic group

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

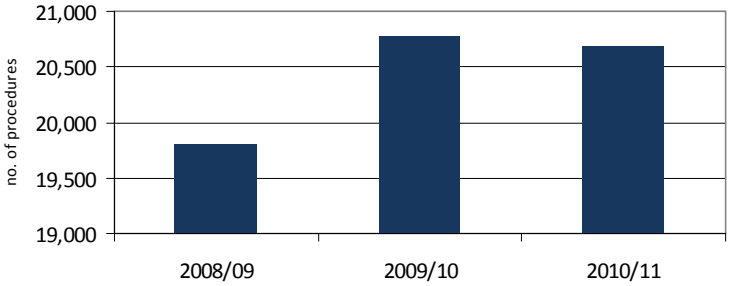
We undertake initiatives & activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
primary care through the GAIHN Contract cancer care coordination (navigation) services for Māori and Pacific populations		10,000 of population		
Pharmacy: Subsidise the community based provision of prescribed pharmaceuticals	Community dispensing of pharmaceutical products subsidised in accordance with PHARMAC stipulations	**Quantity** Total value of subsidy provided Number of prescription items subsidised **Quality** Proportion of prescriptions with a valid NHI number **Timeliness** The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie. any pharmacy open at 8pm on a Sunday)	Good access to effective pharmaceutical treatments Lower per capita out of pocket and total expenditure on pharmaceuticals	Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within 6 months of last discharge

Key: PP = policy priority; OS = ownership dimension

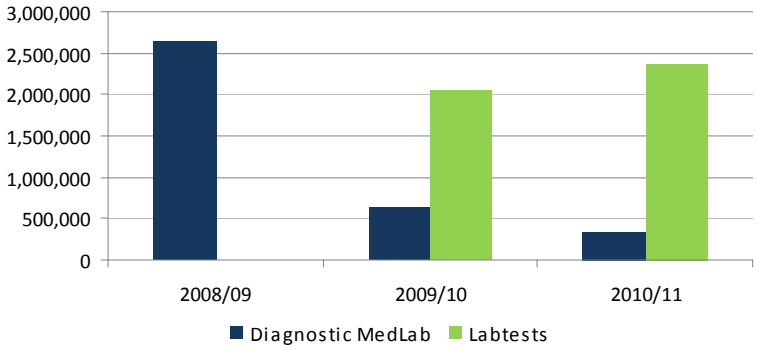
This work contributes to longer term outcomes:

- Improved health
- Greater equity of health outcome
- Living within our means
- Confidence and trust in the health system

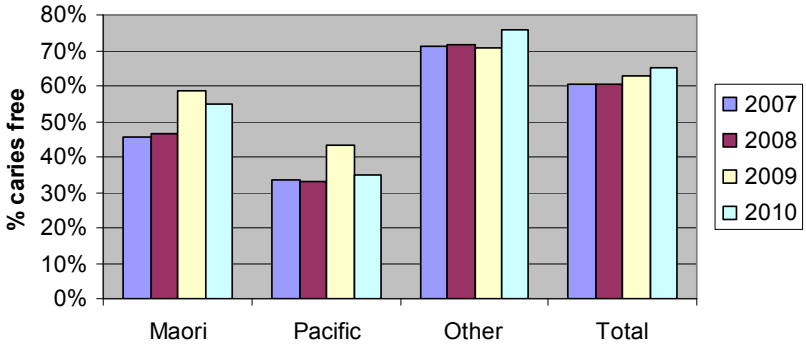
Community referred radiological procedures for Auckland DHB by Year



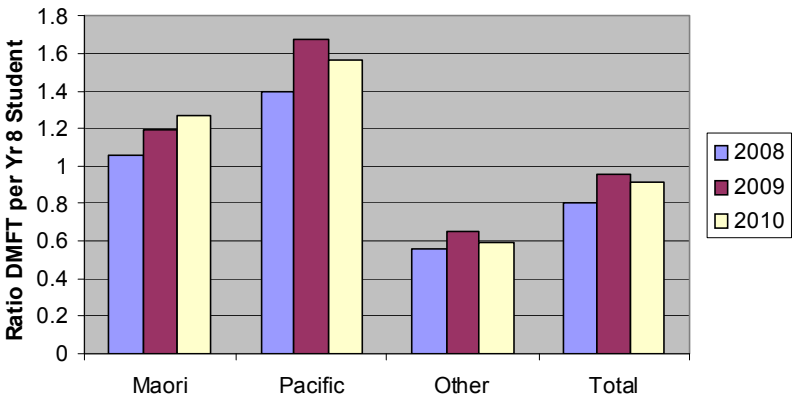
Number of community laboratory tests provided to Auckland DHB residents by provider



Percentage of five year olds free of dental caries: Auckland DHB



Ratio of teeth decayed, missing or filled (DMFT) in year 8 students



5.3 Output Class 3: Intensive Assessment and Treatment

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

They include:

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

On the continuum of care, these services are typically the complex end of treatment services and focussed on people with health problems.

Outputs that relate to this class of activity include:

- Acute (Emergency Department/Inpatient/Outpatient)
- Maternity
- Elective (Inpatient/Outpatient)
- Assessment Treatment & Rehabilitation
- Mental Health

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Acute inpatient services Provide an emergency and acute care service with the following characteristics: – timely access to all service components (including diagnostics) & appropriate	Acute inpatient services Emergency department services	**Quantity** Number of ED attendances (adults and children) Acute WIES total (ADHB provider) **Quality** Readmission rates (OS-8) **Timeliness**	Effective and prompt resolution of medical and surgical emergencies and acute conditions Reduced mortality Improved patient experience of our services Improved engagement of clinicians and other	Age standardised 30 day survival from acute transmural myocardial infarction

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
timely discharge – capacity to meet needs – right treatment in the right place – timely patient transfer to appropriate services from Emergency Department – good access to support services in the community or primary care level to support patient recovery *Activities to achieve the ED length of stay health target is provided in Module 3*		Compliance with national health target of 95% of ED patients discharged admitted or transferred within 6 hours of arrival (Health target) Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	health professionals Patients less likely to be readmitted	
Maternity services: Provide readily accessible maternity, obstetric and neonatal care services	Non-specialist antenatal consultations Obstetric antenatal consultations Postnatal inpatient and outpatient care Labour and birth services Specialist neo-natal inpatient and outpatient care Amniocentesis	**Quantity** Number of births Number of first obstetric consultations Number of subsequent obstetric consults **Quality** Proportion of all births delivered by caesarean section Third/fourth degree tears for all primiparous vaginal births Established breastfeeding at discharge (excl NICU admissions) **Timeliness** Percentage of term elective caesareans performed at >= 39	Safer childbirth Healthier children	APGAR score <= 6 at 5 mins for live term infants Blood loss ≥1500 ml during first 24 hours following a vaginal birth Blood loss ≥1500 ml during first 24 hours following caesarean birth

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
		weeks		
Elective services (inpatient, outpatient): Provide and purchase elective inpatient and outpatient services *Activities to achieve elective surgery health target are in Module 3*	Elective inpatient services Elective outpatient services	**Quantity** Delivery of health target for elective surgical discharges (Health target) Number of first specialist assessment (FSA) outpatient consultations **Quality** % of respondents who rate their care and treatment as very good or excellent **Timeliness** Patients waiting longer than 6 months for their first specialist assessment (ESPI Ministry) Patients given a commitment to treatment but not treated within 6 months (ESPI Ministry)	Restoration of functional independence Increased life expectancy Positive patient experience Improved waiting times for our services Fewer adverse clinical events Patients less likely to be readmitted	Surgical intervention rate
Assessment Treatment and Rehabilitation (Inpatient) Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults *A detailed description of activities for health of older people is in Module 3.*	Sub-acute inpatient care of older adults	**Quantity** Assessment Treatment and Rehabilitation (AT & R) bed days No. of AT&R inpatient events **Quality** Average no. of falls per 1,000 occupied bed days **Timeliness** Proportion waiting 4 days or less from waitlist date to admission to AT&R service	Maximising functional independence and health-related quality of life in older adults	The proportion of patients with an improvement in function between Assessment Treatment and Rehabilitation admission and within 3 days of discharge as measured by a standard test of function (Barthel Index)

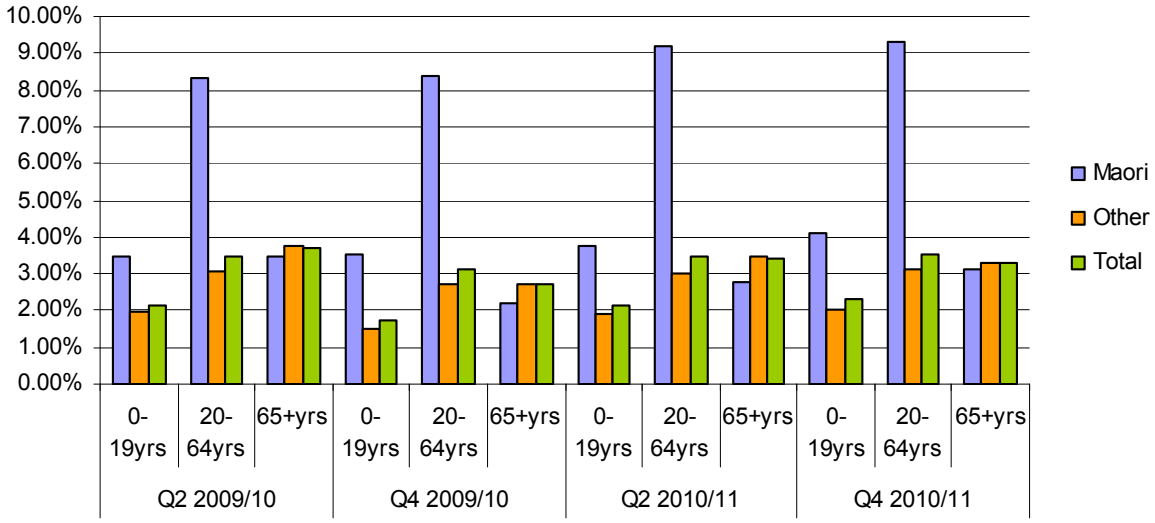
We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Mental health Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands The matrix of services comprise – Acute & Intensive services – Community based clinical treatment & therapy services – Services to promote resilience, recovery and connectedness	**Quantity** Access rates for total and specific population groups (defined as the proportion of the population using Mental Health and Addiction services in the last year) (Policy Priority -6). The population groups for which this indicator is measured are: – Total / child & youth / adult / older adult population (all ethnicities) – Māori (total / adult / child & youth / older adult) **Quality** Proportion of long term clients with Relapse Prevention Plan (target of 95%) in the above population groups (PP-7) **Timeliness** Shorter waits for non-urgent mental health and addiction services (Policy Priority 8)	Prompt recovery from acute mental illness Prevention of mental illness relapses Social integration and improved quality of life	

Key: PP = policy priority; OS = ownership dimension; SI= System integration; ESPI = elective services performance indicators

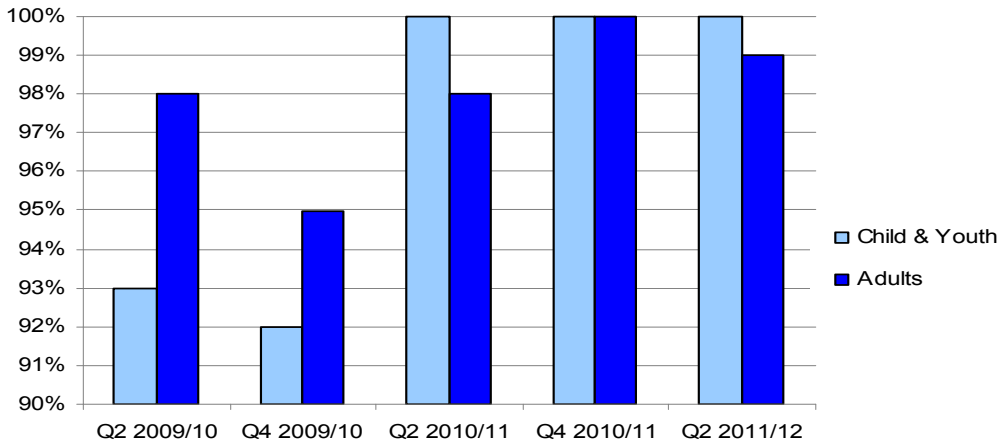
This contributes to outcomes:

Confidence and trust in the health system	Reduced inequities
Improved population health	Living within our means

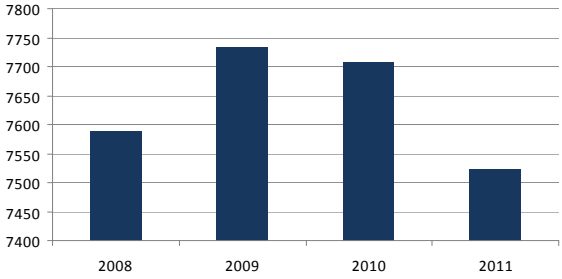
Access rates to Mental Health Services by age and by ethnic groups



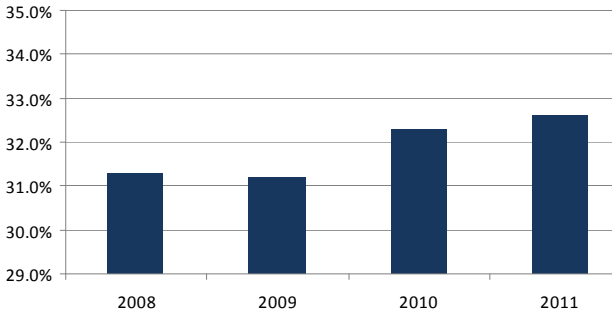
Percentage of Long Term Clients with Relapse Prevention Plans



Number of births



Caesarean section rate (as a percentage of all births)



5.4 Output Class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services. Needs Assessment and Service Coordination (NASC) covers a range of services including palliative care, home-based support services, and residential care services. On a continuum of care, these services provide support and aim to maintain the independence and quality of life of those people with high and complex needs.

Auckland DHB aims to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities; people with mental health problems and people who have age-related disabilities.

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

By helping to restore function and independent living, rehabilitation and support services contribute to improving health-related quality of life. There is some evidence that this may also improve length of life. In addition to its contribution to quality of life, high quality and timely rehabilitation and support services provide patients with a positive experience and a sense of confidence and trust in the health system.

Health inequalities are reduced by targeting rehabilitation and support services to those with the highest need.

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

Outputs that relate to this class of activity include:

- Home Based Support Services
- Age Related Residential Care Beds
- Palliative Care

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Home based support services	Home based support assessments	**Quantity** Total number of InterRAI	Older people with complex needs remain living in their	Proportion of NASC referrals assessed to have high or very

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
Assess and plan the needs of older people for Home Based Support Fund home based support services, delivered in accord with assessed needs	Home based support care	assessments per month **Quality** % of people aged 65 + receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan (PP-18) **Timeliness** % of NASC clients assessed within 6 weeks	home for longer Better health and fewer accidents (e.g. falls) among people over 65 of age Improved happiness and quality of life for older adults	high needs who reside in their own home
Palliative care: Contract or provide high quality generalist and specialist palliative care services	Hospice provided palliative care Specialist community palliative care services Home based palliative care services	**Quantity** Total number of completed episodes of care (death or discharge) **Quality** Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline) **Timeliness** Proportion of patients acutely referred who had to wait > 48 hours for a hospice bed	Improved quality of life for patients with life-threatening illness (and for families/whanau)	Proportion of hospice patient deaths occurring in hospitals versus at home
Residential care services Ensure access to subsidised beds is based on assessed need Ensure sufficient contracted beds are available to people assessed as requiring	Residential care bed days	**Quantity** Total number of subsidised aged residential care bed days **Quality** Proportion of long term residents within the ARRC facilities that have received interRAI training will have an interRAI clinical assessment within 12	Safe care with good management of long term conditions and maximised quality of life for those no longer able to live independently in their own home	Standardised acute admission rates from residential care

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	Impacts measured by
long term residential care		months **Timeliness** Percentage of NASC clients assessed within 6 weeks		

And contribute to outcomes

- People living as independently as possible
- Good quality of life for people who depend on support services
- Support and protections for the ageing population
- Improve quality of life remaining for patients through information, co-ordination and communication

MODULE 6: Service Configuration

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

6.1 Service Coverage and Service Change

Service Change

A provisional list of proposed service changes for implementation in the 2012- 13 year is being developed by the DHB's executive, considering:

- whether the change is directly linked to delivery within a lower future funding path
- if the change is associated with regional clinical services planning
- outlining the process followed for approval of the service change.

Type of Service Change	Area impacted by Service Change	Description of Service Change	Potential risks
Investigations underway for possible integration or merger of services between Waitemata DHB and Auckland DHB	The following areas are already underway: Child Hospital Services Health Service Planning Māori Health Pacific Health Planning and Funding The following areas have been agreed and are commencing: • Central Sterile Supply Department • Employee Relations • Contact centre Further areas will be considered and added over time	Varying models possible from no change, standardisation of processes, and/or sharing of staff & systems through to full service merger. To be determined on a case-by-case basis.	None to-date
Better management of IDF flow		Need to consider any impacts on access from and services in neighbouring DHBs	

Type of Service Change	Area impacted by Service Change	Description of Service Change	Potential risks
Clinical supplies: Cardiac/Cancer	This work may extend to other services. This work may require/ include a service change. The Clinical Practice Committee can be engaged to consider cost effectiveness	Proposal to manage the growth in services and associated use of resources. This will require agreed priority access criteria for high cost services	Service creep over the years is creating a strain on clinical supplies Cost management in the event of technology changes
Mercy Ascot Strategic Alliance	Integration of service with private sector	Services for cancer and cardiac being expanded through private sector agreement	
Birthcare and primary birthing model	Transfers to Birthcare that are clinically appropriate, safe and of choice	Initial meetings held and proposed model of care in development. In the long-term may lead to more focus on securing maternity services in the primary care environment. This may result in volume changes	Clinical safety and patient choice are determinants of where services are provided
Pharmacist Services	Support Better, Sooner, more Convenient care Improve health outcomes for people with Long-Term Conditions Reduce health inequalities. Contain dispensing costs Improve workforce utilisation and community pharmacists working at the top of their scope of practice	Investigate an alternative way of funding community pharmacist services and providing better services for people with Long Term Conditions (those needing additional support) Pharmaceutical dispensing costs are unsustainable with 5-7% year on year increases Current workforce poorly integrated with primary care Little motivation in funding arrangements to focus on health outcomes and management of chronic conditions	This change requires the cooperation of the pharmaceutical sector This national initiative to improve community pharmacist services is working closely with all stakeholders There is a national commitment to review pharmacist services as part of current national agreement

MODULE 7: Financial Performance

7.1 Financial Management

The organisation must not incur any deficits within the allocated funding. This requires reprioritisation and reallocation of resources and investment in tools such as lean thinking and the Health Excellence Framework in order to enable new ways of working, reduce variation and ensure avoidance of waste.

The significant pressure on managing costs, arising from inflationary pressures, new investments and changes in service delivery requirements, means our drive to identify and implement new ways of working throughout the organisation is an imperative. The cost targets within the Annual Plan incorporate the requirement to avoid waste and improve productivity, including clinical resource utilisation and practice change and procurement savings. This includes significant productivity improvement across the organisation and maintaining management and administration FTE numbers below the Minister's cap levels, with the processes and rules for managing below this cap now well established.

Key assumptions within the financial plans include:

- The world and New Zealand economic environment has increased risk and the need for change with established historical practices and expectations not necessarily being applicable in the future, including uncertainty as to the future levels of donation income that will be received and the collection of payments from non-residents.
- Inflation is generally assumed at 2.53% with specific adjustments where future price changes are known. The potential future impact of the forex rate movements is also inherently uncertain in a small economy such as New Zealand operating in a global environment. A one percent inflationary movement in the non-employee operating costs equates to approximately $11 million at Auckland DHB
- Employee terms and conditions are subject to negotiation and interpretation. The impact of employee wage rate settlements have been estimated for inclusion in the financial plans, including agreed MECA settlements through to their expiry date and step increases within the MECA documents plus an allowance for future settlements pending negotiation. An estimate of the impact arising from job sizing has been included within the budget. A one percent variation in employee costs equates to approximately $8 million at Auckland DHB
- Given the inherent uncertainty in predicting future property value movements, it is assumed for budget purposes that there will be no change in the revaluation reserve and no resulting change in the funding arrangements associated with the property revaluations. Under sector policy, funding would change to match any impact of a revaluation on the capital charge paid by the DHB.
- Productivity improvements are to be achieved by increasing the delivery of outputs at a greater rate than the increase in staffing inputs.

Assumptions are made because future events are unknown or uncertain. Assumptions represent a risk in that actual events may vary from the assumption. Similarly, actions which require a change from current processes and activities represent a risk because we cannot guarantee all the outcomes that may flow from the change.

The financial plans include the estimated changes arising from the establishment of Health Alliance as the new northern region shared services organisation. This impacts the presentation of the financial statements, particularly for the 2011-12 and subsequent years. Within the Statement of Financial Performance this mainly comprises reallocating the transferred expenditure and staff to be recorded as an outsourcing payment to the shared services organisation. Within the Statement of Financial Position this mainly comprises transferring certain assets to the shared services organisation with an offsetting financing transaction.

Capital expenditure projects for 2012-13

The majority of capital expenditure is within the Provider Arm services which prioritises its capital expenditure budget. The major projects being undertaken during 2012-13 or proposed for approval during 2012-13 are:

Starship Facilities	Options for the future Starship Children's Health services and facilities are being developed during 2011-12. This will enable the submission of a business case for approval and implementation with the three year planning period.
Building 10 exit and site development	Building 10 is a two-storey, early 1900s structure which covers a key future development area on the Greenlane site. The Building 10 Exit Plan is releasing this area for the development of future facilities. More than half the occupants have already been relocated with plans progressing to relocate the remaining occupants. Auckland DHB holds a Resource Consent to demolish the building by March 2013

Financing for the above projects is planned to be provided from Auckland DHB cash flows and existing debt facilities. This will be specified in further detail within the Starship Facilities business case when it is submitted for Crown approval.

7.2 Managing the Funding

Auckland DHB receives funding from the Crown and is accountable to the Crown for the governance, management and administration activities relating to the allocation of these funds to providers for the provision of health services. District Health Boards are empowered by the New Zealand Public Health and Disability Act to plan, fund and contract for the provision of

health and disability support services for their population (i.e. eligible people domiciled in the DHB area).

Auckland DHB funds most personal health services (including primary care and public hospital services), mental health services and disability services for older people. Public health, disability services (other than age related disability), and some Māori health services are funded by the Ministry of Health.

Auckland's share of the additional funding, made available to DHBs to manage their demographic growth pressure, is lower than our relative population. This is because our resident population has been moving, on average, to a lower health need and reduced socio-economic disadvantage position compared to other DHBs. However, the expected intervention rates for Auckland DHB are higher than what we currently deliver for a range of reasons, e.g. tertiary case-mix complexities.

Funding Envelope components are shown below, based on Ministry of Health advice received in December 2011; and thus allowing a 'like for like' comparison.

Summary of the 2012-13 Funding Envelope (FE)

	FE as per NHB Advice Dec 2011 $m	**Final Budget Review March 2012**	
Population Based Funding	$973.6m increased $32.2m	$1,048.9	1.49% contribution to cost pressure ($15.2m); similar for all DHBs 1.68% contribution to demographic demand pressure ($17m); Counties Manukau DHB received 3.19% and Waitemata DHB 2.15%
Top Slices	$75.3m		National contracts stable at $20.4m with National Services top-up of $24.4m (total $44.8m) Bad Debts increased to $2.6m from $2.3m Primary Maternity from $6.5m to $6.7 (including $129k for implementing new maternity service specifications & data reporting) Land valuation 'subsidy' increased by $100k to $9.2m Long term support services / Chronic health conditions $4.8m from $4.2m Additional Herceptin funding $74k; and last payment for Oral Health Business case development (Clinics) $1.3m
Inter-District Flow (Inflow)	$668.5m	$673.4	The national reference price(s) have been increased by 1.026%* The overall national tertiary compensator pool is $117.2m. Using the Role Delineation Model (adopted in 2011-12), fewer DHBs are now eligible for tertiary funding, plus a recognition of higher tertiary centre cost pressures (i.e. in 2012-13, a 13.9% increase in size of pool)
Inter District Flow (Outflow)	-$110.4m	-$115.8	FE figure is based on Ministry of Health Forecast Schedule, with Pharms & Labs to be finalised (as per the March budget figure). Volume growth over last 5 years is at 0.14% with price growth at 3.34%
Revenue	**$1.607**	**$1,606.5**	**Total Funding Envelope revenue**

* *All the IDF prices were reworked based on the 2010-11 average costs and the tertiary adjuster changes. This gave a new starting point for prices for 2012-13 and then 1.49% price applied. The result increased the tertiary adjuster pool with lower level of increase for CWD/Non DRGs.*

The table relates to the Funding Envelope monies and excludes 'other revenue' such as donations ($9.2 million); Training ($21 million). The Funding Envelope also excludes Well Child/ Tamariki Ora funding ($2m). Key areas of risk are also noted at the end of this module.

Over the year, there are usually some adjustments made on Inter District Flows and other items such as devolution of services and other national services, leading to ongoing revisions of the Auckland DHB's Funding Envelope amount.

The Funding Envelope, together with various national service priorities and local population demands, has implications for Auckland DHB: these are risks with associated longer-term strategic implications (module 2), service issues (module 6) or financial issues (this module).

Allocating the Funding

Overall funding allocations and service volume schedules, based on the funding envelope received in January 2012 have been developed.

The principles for the allocation of funding are to, while living within our means:

- maintain Auckland DHB base services to meet acute demand
- continue with improving the performance on the six National Health Targets and other Ministry of Health performance requirements and implement other Government initiatives and commitments, including the Minister's Letter of Expectations
- address other Auckland DHB Board's priorities (module 2)

As a result, organisational budget cost levels for 2012-13 have been proposed for Auckland DHB to remain within budget overall. Services are expected to maintain 2012-13 costs within the targets while delivering the required service types and volumes.

Service Delivery Volumes

Overall there is a 0.73% increase in case-weighted discharge volumes compared with the budget for the 2011-12 year. For Auckland, the planned volume increase is 1.45%. This is primarily driven by the increase in elective volumes (it should be noted that a further increase in elective volumes has been proposed by the Ministry of Health subsequent to this production plan being prepared and it is therefore currently assumed for budget purposes that this increase will be delivered through outsourcing).

The overall 0.37% decrease in acute volumes is due to the planned acute volumes from IDF referrals decreasing. Other DHBs are planning a repatriation of referred services of approximately $14 million for the 12/13 year which reduces revenue and means that cost structures need to be adjusted in order to mitigate against the revenue reduction.

Changes in service delivery volumes for the Provider Arm

Provider Arm Operational HSG Production Plan	IDF Status	1112 PVS Oct 11	1213 PVS June 12	Vol Mvmt	Vol Var %
Acute (Caseweights)	National	2,033	2,299	265	13.05%
	Local	49,738	50,019	281	0.56%
	IDF	41,167	40,409	- 757	-1.84%
Acute Total		92,938	92,727	- 211	-0.23%
Elective (Caseweights)	National	2,467	2,350	- 118	-4.77%
	Local	15,592	16,262	670	4.30%
	IDF	16,020	16,606	586	3.66%
Elective Total		34,079	35,218	1,139	3.34%
Total Caseweights		127,017	127,944	927	0.73%
Auckland Population Caseweights		65,330	66,281	951	1.46%
FSA(Sum of attendances)	National	1,701	2,651	950	55.87%
	Local	47,004	49,103	2,099	4.47%
	IDF	33,707	32,762	- 946	-2.81%
FSA Total		82,412	84,516	2,104	2.55%
FU(Sum of attendances)	National	2,696	4,502	1,806	66.98%
	Local	121,927	122,700	773	0.63%
	IDF	108,138	105,454	- 2,684	-2.48%
FU Total		232,761	232,656	- 105	-0.05%
Other Non DRG*	National	677,198	582,945	- 94,252	-13.92%
	Local	29,412,450	33,960,179	4,547,729	15.46%
	IDF	65,662,852	81,153,553	15,490,701	23.59%
Total Other Non DRG		95,752,499	115,696,677	19,944,178	20.83%

* As recorded in Price volume Schedule

Oncology volumes are not growing at the rate expected by the regional cancer network when the models of care and service delivery structures were developed. This means that either regional capacity funding is required to maintain the agreed service delivery model or cost reductions will be required through changes to the current service delivery model.

Other Revenue

Other sources of revenue not received through the Funding Envelope include ACC ($1.2m increase), pharmacy sales ($1.7m increase), donations ($5m increase from Starship Level 6 project) and interest income ($1m decrease through funds used for new facilities).

Production Plan, Summary Total

Unit of Measure	Auckland Population	Other Populations	National Service
Assessments (#)	10,828	85	165
Attendance (#)	370,768	447,056	8,103
Bed Days (#)	5,100	-	
Client (#)	319,450	11,408	-
Contact (#)	171,076	34,152	936
Cost weighted discharge(WD)	66,281	57,124	4,648
Day Attendance (#)	812	-	
Emergency Department Attendance (#)	34,625	10,242	
Event (#)	104	-	530
Fitting of a Prosthetic eye (#)	17	64	
Hour (#)	13,800	-	
Implant only (#)	-	3	
Meal (#)	140,208	-	
Occupied bed day (#)	36,717	151	
Patient (#)	1,046	98	
Prescription (#)	33,749	81,777	
Procedure ($)	11,754	8,090	187,454
Programme ($)	16,386,090	10,549,361	392,105
Relative Value Unit (#)	33,250	11,987	
Service ($)	10,158,575	14,876,781	
Test (#)	691,522	678,124	
Treatment (#)	3,985	2,143	
Visit (#)	6,829	-	
Written plan of care (#)	3,200	1,419	803

7.3 Consolidated Financial Tables

Table 1: Statement of financial performance

STATEMENT OF FINANCIAL PERFORMANCE	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
REVENUE					
Base Funding					
Population Based	961,595	991,839	1,047,368	1,075,520	1,103,671
Inter District Inflows	610,327	683,164	666,128	689,443	713,574
	1,571,922	1,675,003	1,713,496	1,764,963	1,817,245
Side Contracts with Ministry of Health					
Additional Electives	22,768	23,840	26,639	27,463	28,303
Sector Capability & Innovation	18,190	24,878	25,137	25,914	26,707
Other Side Contracts	65,860	64,382	60,535	62,408	64,317
	106,818	113,100	112,311	115,786	119,327
Other Revenue					
External Sales	106,677	98,022	104,718	108,201	111,222
Training	20,102	21,083	20,539	21,174	21,822
Donations	6,358	4,842	9,058	3,851	3,851
Financial	9,285	11,041	8,224	3,491	3,491
	142,423	134,988	142,538	136,716	140,386
TOTAL REVENUE	**1,821,162**	**1,923,091**	**1,968,346**	**2,017,465**	**2,076,958**
OPERATING COSTS					
Employee Costs	727,850	752,088	768,034	773,197	792,882
Outsourced Services	55,244	87,573	79,705	82,870	86,242
Treatment Costs	245,350	243,017	251,599	264,088	274,836
Funder Payments	515,719	572,012	591,287	607,180	623,072
Inter District Outflows	99,532	109,213	114,556	118,566	122,715
Property & Equipment Maintenance	50,765	44,101	47,101	48,961	50,954
Administration	22,704	24,034	23,504	24,437	25,432
TOTAL OPERATING COSTS	1,717,163	1,832,038	1,875,786	1,919,298	1,976,133
OPERATING SURPLUS/(DEFICIT)	103,999	91,053	92,560	98,168	100,825
NON OPERATING COSTS					
Depreciation	51,146	40,240	43,701	46,436	49,087
Interest	18,219	17,767	15,875	18,717	18,717
Capital Charge	34,491	32,850	32,892	32,920	32,924
TOTAL NON OPERATING COSTS	103,857	90,857	92,468	98,073	100,728
SURPLUS/(DEFICIT) FOR THE YEAR	**142**	**196**	**92**	**94**	**96**

Table 2: Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
SURPLUS/(DEFICIT) FOR THE YEAR	142	196	92	94	96
OTHER COMPREHENSIVE INCOME					
Gains/Losses on Property Revaluations	(21,557)	(0)	-	-	-
TOTAL COMPREHENSIVE INCOME	**(21,415)**	**196**	**92**	**94**	**96**

Table 3: Cost of service statement

COST OF SERVICE STATEMENT	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
Governance & Funding Administration					
Revenue	5,057	6,835	6,521	6,723	6,932
Expenses	(4,893)	(7,543)	(8,814)	(9,070)	(9,333)
Net Surplus/(Deficit) - Governance & Funding Administration	**163**	**(708)**	**(2,293)**	**(2,346)**	**(2,401)**
Provider					
Revenue	1,178,057	1,209,447	1,247,018	1,273,776	1,310,215
Expenses	(1,198,802)	(1,231,056)	(1,250,212)	(1,278,505)	(1,316,569)
Net Surplus/(Deficit) - Provider	**(20,746)**	**(21,609)**	**(3,194)**	**(4,730)**	**(6,354)**
Funder					
Revenue	1,651,460	1,759,307	1,794,980	1,850,624	1,907,994
Expenses	(1,630,735)	(1,736,795)	(1,789,401)	(1,841,294)	(1,894,691)
Net Surplus/(Deficit) - Funder	**20,725**	**22,512**	**5,579**	**9,331**	**13,303**
Elimination					
Revenue	(1,013,411)	(1,052,498)	(1,080,173)	(1,113,658)	(1,148,182)
Expenses	1,013,411	1,052,498	1,080,173	1,111,498	1,143,731
Net Surplus/(Deficit) - Elimination	-	-	-	**(2,160)**	**(4,450)**
Total					
Revenue	1,821,162	1,923,091	1,968,346	2,017,465	2,076,958
Expenses	(1,821,020)	(1,922,896)	(1,968,254)	(2,017,370)	(2,076,861)
SURPLUS/(DEFICIT) FOR THE YEAR	**142**	**195**	**92**	**94**	**97**

Table 4: Statement of changes in equity

STATEMENT OF CHANGES IN EQUITY	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
Balance as at 1 July	454,575	436,854	440,408	440,500	440,594
Total Comprehensive Income	(21,415)	196	92	94	96
Capital Contributions from the Crown	3,694	3,358	-	-	-
Balance as at 30 June	**436,854**	**440,408**	**440,500**	**440,594**	**440,691**

Table 5: Statement of financial position

STATEMENT OF FINANCIAL POSITION	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
ASSETS					
CURRENT ASSETS					
Cash, Bank Balances & Investment Bonds	89,292	72,862	23,000	(26,739)	(18,692)
Term Deposits	-	31,500	31,500	31,500	31,500
Restricted Trust & Patient Funds	13,193	10,100	10,100	10,100	10,100
Receivables and Prepayments	59,223	65,724	67,028	68,210	69,802
Inventories	12,021	12,000	11,369	11,721	12,080
Non Current Assets held for Sale	20,041	-	-	-	-
	193,770	192,186	142,997	94,792	104,789
NON CURRENT ASSETS					
Restricted Trust & Patient Funds	3,898	2,145	2,145	2,145	2,145
Property, Plant and Equipment	829,098	839,341	875,944	928,717	927,026
Intangible Assets	536	889	900	2,392	3,446
Derivatives in Gain	5,945	7,657	5,907	4,361	3,299
Investment in Associates	502	11,763	17,027	17,027	17,027
	839,979	861,794	901,923	954,641	952,942
TOTAL ASSETS	1,033,749	1,053,980	1,044,920	1,049,433	1,057,731
LIABILITIES					
CURRENT LIABILITIES					
Trade and Other Payables	149,465	140,384	146,400	148,694	152,042
Employee Benefits & Provisions	136,566	140,732	124,892	126,853	130,733
Borrowings	24,638	63,572	13,802	123,826	103,931
Funds held in Trust	1,093	1,139	1,175	1,211	1,247
	311,762	345,827	286,269	400,583	387,953
NON - CURRENT LIABILITIES					
Employee Benefits	21,748	23,535	23,836	23,836	24,565
Borrowings	263,108	244,211	294,315	184,418	204,522
Derivatives in Loss	276	-	-	-	-
	285,132	267,746	318,151	208,255	229,087
TOTAL LIABILITIES	596,894	613,573	604,420	608,838	617,040
EQUITY					
Public Equity	573,103	576,461	576,461	576,461	576,461
Accumulated Deficit	(477,237)	(477,041)	(476,949)	(476,855)	(476,758)
Revaluation Reserve	331,981	331,981	331,981	331,981	331,981
Trust/Special Funds	9,007	9,007	9,007	9,007	9,007
TOTAL EQUITY	436,854	440,408	440,500	440,594	440,691
NET ASSETS	1,033,748	1,053,981	1,044,920	1,049,432	1,057,731

Table 6: Statement of cash flows

STATEMENT OF CASH FLOWS	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Cash was provided from					
Provision of Health Services	1,814,673	1,906,853	1,961,280	2,013,308	2,071,909
Interest Received	6,617	7,045	6,974	3,491	3,491
	1,821,290	1,913,898	1,968,254	2,016,799	2,075,400
Cash was applied to					
Employee Costs	(715,730)	(746,135)	(783,572)	(771,236)	(788,272)
Other Operating Costs	(1,000,330)	(1,102,920)	(1,118,059)	(1,158,129)	(1,194,319)
	(1,716,060)	(1,849,055)	(1,901,631)	(1,929,365)	(1,982,591)
Net Cash Flow from Operating Activities	**105,230**	**64,843**	**66,622**	**87,434**	**92,808**
INVESTING ACTIVITIES					
Cash was provided from					
Proceeds from Sale of Fixed Assets	268	24,543	11,662	17,134	17,134
Decrease/(Increase) in Restricted Trust & Financing Funds	(1,235)	(26,608)	36	36	36
Decrease/(Increase) in Investment in Associates		(11,261)	(5,264)	-	-
	(967)	(13,327)	6,434	17,170	17,170
Cash was applied to					
Purchase of Fixed Assets and Intangibles	(51,547)	(55,303)	(91,836)	(117,164)	(64,914)
Net cash (Outflow) from Investing Activities	**(52,514)**	**(68,630)**	**(85,402)**	**(99,994)**	**(47,744)**
FINANCING ACTIVITIES					
Proceeds from Capital Raised/(Repaid)	3,694	3,358	-	-	-
Interest Paid	(14,950)	(17,994)	(15,542)	(18,589)	(18,508)
Proceeds from Loans Raised	-	19,989	-	-	-
Net cash (Outflow) from Financing Activities	**(11,256)**	**5,353**	**(15,542)**	**(18,589)**	**(18,508)**
OPENING BANK BALANCE	**47,832**	**71,296**	**57,321**	**4,410**	**(45,248)**
NET CASH INFLOW/(OUTFLOW)	**41,460**	**1,566**	**(34,321)**	**(31,149)**	**26,556**
CLOSING BANK BALANCE	**89,292**	**72,862**	**23,000**	**(26,739)**	**(18,692)**

Table 6 (cont): Statement of cash flows

RECONCILIATION OF OPERATING DEFICIT WITH CASH FLOWS FROM OPERATING ACTIVITIES	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
Total Surplus/(Deficit) for the Year	142	196	92	94	96
Non - Cash Items					
Depreciation and Impairment Losses	51,146	40,240	43,701	46,436	49,087
(Gains)/Losses on Financial Instruments	2,288	(1,988)	1,750	1,546	1,062
Amortisation of Borrowing Costs	96	94	104	104	104
	53,530	38,346	45,555	48,086	50,253
Items Classified as Investing Activities					
Gain on Sale of Property Plant and Equipment	-	(34)	(142)	(670)	(670)
Items Classified as Investing Activities					
Interest Paid	14,950	17,994	15,542	18,589	18,508
Movements in Working Capital					
(Increase)/Decrease in Receivables	(4,847)	(6,501)	(1,304)	(1,182)	(1,592)
(Increase)/Decrease in Inventories	(905)	21	631	(352)	(359)
Increase/(Decrease) in Payables	42,360	32,815	21,791	41,457	45,079
	36,608	26,335	21,117	39,924	43,129
Net Cash Flow from Operating Activities	105,230	64,843	66,622	87,434	92,808

Table 7: Balance sheet equity ratio

BALANCE SHEET EQUITY RATIO	2010-11 Actual $'000	2011-12 Forecast $'000	2012-13 Plan $'000	2013-14 Esimate $'000	2014-15 Esimate $'000
Equity Position					
Crown Equity	(426,754)	(430,262)	(430,318)	(430,376)	(430,437)
Trust Equity	(10,100)	(10,146)	(10,182)	(10,218)	(10,254)
Total Equity	(436,854)	(440,408)	(440,500)	(440,594)	(440,691)
	-	-	-	-	-
Total Debt					
Bank					
Bonds	(50,000)	(50,000)	(50,000)	(50,000)	(50,000)
Crown Funding Authority	(233,500)	(254,500)	(254,500)	(254,500)	(254,500)
	(283,500)	(304,500)	(304,500)	(304,500)	(304,500)
Total Debt	(283,500)	(304,500)	(304,500)	(304,500)	(304,500)
Total Debt + Equity	(720,354)	(744,908)	(745,000)	(745,094)	(745,191)
Equity Ratio - to be less than 65%	**39.4%**	**40.9%**	**40.9%**	**40.9%**	**40.9%**

Table 8: Summary of results by output class (module 5)

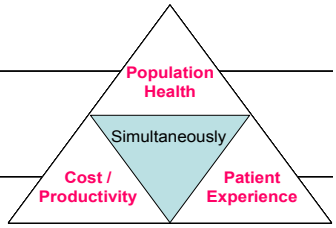
Output Class Service		Actual 2011 $'000	Forecast 2012 $'000	Plan 2013 $'000	Estimate 2014 $'000	Estimate 2015 $'000
Early Detection & Management	Revenue	532,936	559,692	579,921	594,393	611,921
	Expenditure	(543,832)	(557,294)	(571,462)	(585,732)	(603,008)
	Surplus/(Deficit)	**(10,896)**	**2,398**	**8,459**	**8,661**	**8,912**
Intensive Assessment & Treatment	Revenue	1,101,509	1,199,002	1,212,093	1,242,340	1,278,976
	Expenditure	(1,093,310)	(1,189,010)	(1,204,855)	(1,234,910)	(1,271,321)
	Surplus/(Deficit)	**8,199**	**9,992**	**7,238**	**7,430**	**7,655**
Rehab & Support	Revenue	159,196	144,925	155,415	159,294	163,991
	Expenditure	(157,746)	(155,807)	(169,517)	(173,749)	(178,874)
	Surplus/(Deficit)	**1,450**	**(10,882)**	**(14,101)**	**(14,456)**	**(14,883)**
Prevention Services	Revenue	27,521	19,471	20,917	21,438	22,071
	Expenditure	(26,132)	(20,783)	(22,420)	(22,980)	(23,658)
	Surplus/(Deficit)	**1,389**	**(1,312)**	**(1,503)**	**(1,541)**	**(1,587)**
Total	Revenue	1,821,162	1,923,091	1,968,346	2,017,465	2,076,958
	Expenditure	(1,821,020)	(1,922,895)	(1,968,254)	(2,017,371)	(2,076,861)
	Surplus/(Deficit)	**142**	**196**	**92**	**94**	**97**

MODULE 8. Appendices

Appendix 1. Northern Region Health Plan

Overarching framework

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



Our Region's Strategic Challenges

- Inequalities in health status and health outcomes linked to ethnicity and socio-economic deprivation
- Demand for health care services, and particularly acute care, is predicted to exceed the level of health care resources
- The cost of providing publicly funded health services is growing at an unsustainable rate, influenced by demand pressures, new technologies and labour costs
- Delivery of care is fragmented between primary and secondary services and is based around an episodic model of care which does not work well for people with long term and complex conditions
- There are substantial human and financial costs to our community associated with failures in health and disability services.

Our Strategic Goals

Areas of Focus & High Level Objectives	1. **Population Health: Lift Health Outcomes of Northern Region Population; Life and years (Longer, healthier, more independent lives); and reduce health inequalities**	2. **Patient Experience: Better Services; First do no harm; Informed choice; and performance improvement**	3. **Cost / Productivity: Ensure capacity to meet demand whilst living within our means**
	The Northern region has seven areas of focus within a 'Life and Years' programme of work: • Diabetes • Cancer • Cardiovascular disease • Child health • Outcomes for older people • Respiratory Disease • Mental health and Addiction For each of these areas of focus the intent is to improve health outcomes by ensuring regional equity of access to care, improved treatment times; appropriate screening mechanisms and delivery of whole of system care. High level objectives are to minimise impacts from disease or condition. For the identified areas of focus this will be evidenced by : 1.1 Achievement of Outcome Targets; eg measures relating to: 1.11 National Health Targets 1.12 Time: treatment timeframe, 1.13 Demand: acute presentations, bed-day reductions 1.14 Identification of Target population : eg risk assessment rates, target rates for clinical assessments management plan initiation etc 1.15 Condition progression 1.16 Incidence or rates of significant events of interest 1.2 Integration of care across primary and secondary services 1.3 Improved communication and collaborative approaches between health and other social agencies 1.4 Regionally consistent response and methodology for care delivery; 1.41 Development and regional implementation of clinical care guidelines / pathways 1.42 Development and regional implementation of regionally consistent supporting processes 1.5. Improvements in KPIs 1.51 Measures reflecting the safety and quality of care 1.52 Improvements in measuring capability 1.6. Development and support of workforce to meet demand 1.61 Capability 1.62 Capacity 1.63 Change leadership 1.64 Culture 1.7 Alignment of capacity and demand	We will raise the patient experience across all services and ensure: 2.1 Improved safety and quality with a particular focus on: • Falls causing harm • Pressure injuries • CLAB • Medications safety • Transfers of care This will be evidenced by : 2.11 Achievement of Outcome Targets Incidence or rates of significant events of interest 2.12 Implement regionally consistent definitions and baseline data to support KPIs 2.13 Improve the region's use of Global Trigger Tool (GTT) 2.14 Improve transfer of care 2.15 Establish regional 'toolkit' repository 2.2 Informed patient choice to achieve greater patient participation and to ensure patients get appropriate care that best suits their context. The Northern region initial focus: advanced care planning: 2.21Consistent Advanced Care Planning; pilot, promote, consolidate 2.3 Appropriate health and disability services are able to be accessed in a timely manner when needed 2.31 Rapid access for patients with acute needs 2.32 Improved access to elective services to restore/ maintain peoples' functional independence 2.33 Maintain / reduce target wait times for patients accessing the hospital system	The Northern region will consider cost and productivity issues in all work undertaken. This will include ensuring that: 3.1 Regional resources are used effectively and services delivered efficiently with minimal wastage 3.2 Capacity and demand are aligned 3.21 Focussed action to reduce the demand from people entering 'downstream' care paths 3.22 Capacity requirement planning to meet future models of care 3.3 Infrastructure and assets are managed to ensure safe, efficient, effective and affordable services evident by 3.31 Regional collaboration on capital planning 3.32 Delivering major infrastructure developments on time within budget 3.4 Regional radiology services are improved by focus on access to, and timeliness of, radiology diagnostics 3.5 We work in partnership to effectively influence health and wellbeing outcomes evident by 3.51Improving involvement of internal and external partners in the planning and provision of health services 3.6 We Invest in information systems and technology in priority areas: 3.61 Common PAS 3.62 Single clinical workstation 3.63 Regional clinical data repository 3.64 Population health data repository 3.35 IS Infrastructure 3.36 Safe Medication Management 3.37 Shared care plan

Appendix 2. Performance Indicators

2012/13 Performance Measures

The current monitoring framework aims to provide the Minister with a rounded view of performance using a range of performance markers. Four dimensions are identified that reflect DHBs functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and Supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on government priorities. Each target and performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Policy Priorities Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
PP1 Clinical leadership self assessment			
The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: • Contributing to regional clinical leadership through networks • Investing in the development of clinical leaders • Involving the wider health sector (Including primary and community care) in clinical inputs • Demonstrating clinical influence in service planning • Investing in professional development • Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care			
The DHB provides a qualitative report as follows: 1. Those DHBs with BSMC Alliance are required to submit jointly agreed • Year Two Implementation Plans by 31 December 2011 or earlier. • Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Two Implementation Plans including resolution plans for any areas of slippage against deliverables • Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services. 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions i.e. CVD/Diabetes) including: o Identification of and achievement against targets for the number of people that are expected to be appropriately managed in a primary/community setting instead of secondary care	No quantitative target qualitative deliverable required. Baseline Q1	NA	Quarterly

o Identification of and achievement against targets for growth reduction in ED attendance, acute inpatient admissions and bed days o Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations) o Identification of, and achievement against new service activity in quantified patient terms • Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Identification of and progress against the activities to ensure free after-hours services to children under six years of age. Additional reporting deliverable required for Quarter 4: Each DHB must provide a report with the following information: • each PHO's working capital requirements • each PHO's total cash balance and total income in advance at the end of the financial year • the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level, and • a copy of the relevant PHO's forecast expenditure plans.			Baseline Q1 10% Baseline Q1 Qualitative deliverable required		

PP6 Improving the health status of people with severe mental illness

The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for Māori and in total • adults aged 20-64, specified for Māori and in total • older people aged 65+, specified for Māori and in total.	**Age 0-19**	Māori	4.08%	NA	Six-Monthly
		Total	2.53%		
	Age 20-64	Māori	8.18%		
		Total	3.3%		
	Age 65+	Total	3.58%		

PP7 Improving mental health services using relapse prevention planning

Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Māori	95%%	**95%**	Six-Monthly
		Non Māori	95%	**95%**	
	Child & Youth	Māori	95%	**95%**	
		Non Māori	95%	**95%**	

PP8 Shorter waits for non-urgent mental health and addiction services

80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks. Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD A narrative is required to: 1. identify what processes have been put in place to reduce waiting times 2. explain variances of more than 10% waiting times target Update: Adjustment to reporting template. Adjusted to include child and youth NGO services (for Midland region only)	**Mental Health Provider Arm** **<= 3 weeks** / **<=8 weeks** **Age** / **Baseline** / **Target** / **Baseline** / **Target** 0-19: 48.4% / 60.0% / 71.5% / 80.0% 20-64: 67.6% / 75.0% / 76.7% / 85.0% 65+: 56.3% / 65.0% / 84.3% / 95.0% **Addictions (Provider Arm and NGO)** **<= 3 weeks** / **<=8 weeks** **Age** / **Baseline** / **Target** / **Baseline** / **Target** 0-19: 75.0% / 80.0% / 75.0% / 85.0% 20-64: 61.7% / 75.0% / 78.5% / 85.0% 65+: 83.3% / 80.0% / 100.0% / 95.0%	**80%** of people referred for non-urgent mental health or addiction services are seen within 3 weeks and **95%** of people are seen within 8 weeks.	Six-Monthly

PP10 Oral Health DMFT Score at year 8 Transitional measure (not included in performance dashboard reports)				
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and (ii) children who are caries-free (decay-free).	Total	ratio 0.80 year 1 0.63 year 2	NA	Annual
	Maori	ratio 0.80 year 1 0.63 year 2		
	Pacific	ratio 0.80 year 1 0.63 year 2		
PP11 Children caries free at 5 years of age Transitional measure (not included in performance dashboard reports)				
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – • Decayed (d), • Missing (due to caries, m), and • Filled (f).	Total	ratio 69 year 1 74 year 2	NA	Annual
	Maori	ratio 69 year 1 74 year 2		
	Pacific	ratio 69 year 1 74 year 2		
PP12 Utilisation of DHB funded dental services by adolescents Transitional measure (not included in performance dashboard reports)				
In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: (i) the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.	Total	Year 1 77% Year 2 85%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services				
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).	Children Enrolled **0-4 years**	Year 1 73% Year 2 79%	NA	Annual
Measure 2 - In the year to which the reporting relates:(i) the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers); and (ii) the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.	Children not examined **0-12 years**	Year 1 10% Year 2 7%		
PP16 Workforce - Career Planning				
The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: ● Medical staff ● Nursing ● Allied technical ● Maori Health ● Pacific ● Pharmacy ● Clinical rehabilitation ● Other		No quantitative target. Supply of quantitative data required.	NA	Annual

PP18 Improving community support to maintain the independence of older people				
Numerator: The number of people aged 65 and older receiving long-term home-support services who have had a Comprehensive Clinical Assessment and a completed care plan in the previous twelve months. Denominator: The number of people aged 65 and older who have received long-term home-support services in the last twelve months. Update: adjustment to definitions both numerator and denominator (timeframes)		95%	95%+	Quarterly
PP 20 Improved management for long term conditions (CVD, diabetes and Stroke)				
Part 1, Focus area 1: Cardiovascular disease DHBs supply a quarterly narrative report that comments on data supplied by the Ministry, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14		No quantitative target Progress to be demonstrated via qualitative deliverable	NA	Quarterly
Part 1, Focus area 2: Stroke services DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services				
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews Numerator - Count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period Denominator - The number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data Source: PHO Performance Programme Indicators Definitions 1 July 2011 version 5.3 Sept11		60%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each Improvement area identified in the Annual Plan		Qualitative deliverable.		
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service).. Provide the annual report from the local diabetes team to the Ministry as outlined in the Service Specification for Specialist Medical and Surgical Services – Diabetes Service – Local Diabetes Team Service (or an equivalent service)				Annual
Part 2, Focus area 3. Diabetes Management Numerator: (Data source: DHB to provide). The number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64% at their free annual check during the reporting period Denominator: (Data source: DHB to provide. Note that this is the numerator from the Diabetes Free Annual Check indicator) The number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period	Māori	80%		Quarterly
	Pacific	80%		
	Total	80%		
PP 21 Ensure Immunisation cover for two year olds				
Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan The Ministry will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/		95%	95%	Quarterly

System Integration Dimension					
Performance Measure and description			**2012/13 Target**	**National Target**	**Frequency**
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds	**Age 0-74**	Māori	Rate <95	NA	Six-Monthly
		Pacific	Rate <95		
		Total	Rate <95		
	Age 0-4	Māori	Rate <95		
		Pacific	Rate <95		
		Total	Rate <95		
	Age 45-64	Māori	Rate 103		
		Pacific	Rate 103		
		Total	Rate 103		

SI2 Regional service planning				
A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan For each action the progress report will identify: • the nominated lead DHB/person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan		No quantitative target Progress to be demonstrated via qualitative deliverable.	NA	Quarterly
SI3 Ensuing delivery of Service coverage				
Exception report - Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:• analysis of explanatory indicators• media reporting • risk reporting• formal audit outcomes• complaints mechanisms• sector intelligence.		No quantitative target exception based qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates				
Data sourced from National Minimum Dataset. Exception report - For any procedure where the standardised intervention rate in the 2011/12 financial year is significantly below the target level a report demonstrating: 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved	**Major joint replacement procedures**	21.0 per 10,000	21.0 per 10,000	Annual quarter1
	Cataract Procedures	27.0 per 10,000	27.0 per 10,000	
Cardiac Procedures Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved.		6.2 per 10,000	For cardiac surgery a target intervention rate of between 6.2 and 6.5 per 10,000	Quarterly
		11.9 per 10,000	For percutaneous revascularization a target rate of at least 11.9 per 10,000	
		32.3 per 10,000	For coronary angiography services a target rate of at least 32.3 per 10,000	

SI5 Delivery of Whānau Ora					
The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives, steps towards improving service delivery within these providers, and supporting the building of mature providers. This will include a summary of the following – how the DHB is: • Contributing to the strategic change for Whānau Ora in the district • Contributing information about Whānau Ora within the district at appropriate forums, including nationally. • Investing in Whānau Ora Provider Collectives through deliberate activities • Involving the DHB's governors and management in the Whānau Ora activity in the district • Demonstrating meaningful activity moving towards improved service delivery and building mature providers.			No quantitative target qualitative deliverable required.	NA	Annual

SI7 Improving breast-feeding rates					
DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Māori	74%	**74%**	Annual
		Pacific	74%		
		Total	74%		
	3 Months	Māori	61%	**57%**	
		Pacific	61%		
		Total	61%		
	6 Months	Māori	29%	**27%**	
		Pacific	29%		
		Total	29 %		

Note: we are working towards the achievement of these targets, aiming to close the gap between ethnicities in the medium term

Ownership Dimension			
Performance Measure and description	**2012/13 Target**	**National Target**	**Frequency**
OS3 inpatient length of stay			
Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating: 1.what analysis the DHB has done to review the appropriateness of its rate AND 2.whether the DHB considers the rate to be appropriate for its population OR 3.a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved.	4.02 Days	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly
OS5 Theatre Utilisation			
Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: a. For DHBs whose overall utilisation is less than 85%, a target that is a substantial incremental step towards achieving the 85% target is recommended b. For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	85%	85%	Quarterly

OS6 Elective and arranged day surgery			
Data sourced from National Minimum Dataset. Exception report - The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.	60%	59.2% Standardised	Quarterly
OS7 Elective and arranged day of surgery admissions			
The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. Update: Exclusion of inter-hospital transfers since high volumes of inter-hospital transfers limits the ability of tertiary hospitals to achieve targets. Change to reflect expectations calculated in WIES 11	68%	For DHBs with a 2011/12 Quarter 3 result that is below 90 percent, their suggested target is 90 percent. For DHBs with a 2011/12 Quarter 3 result that is between 90 and 95 percent, their suggested target is 95 percent. For DHBs with a 2011/12 Quarter 3 result that is above 95 percent, their suggested target will be to maintain current levels.	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Data sourced from National Minimum Dataset. Exception report - Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. Update: change to reflect expectations calculated in WIES 11	%TBA	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly

OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)	6%	Greater than 3.00% and less than or equal to 6.00%	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	2%	Greater than 0.50% and less than or equal to 2%	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	55%	Greater than or equal to 55.00% and less than 65.00%	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter	5%	Greater than 2.00% and less than or equal to 5.00% late	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	97%	Greater than or equal to 97.00% and less than 99.50%	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarterDenominator: Total number of PRIMHD records submitted by the DHB in the quarter	98%	Greater than or equal to 98.0% and less than 99.5%	

Output Dimension			
Performance Measure and description	**2012/13 Target**	**National Target**	**Frequency**
OP1 Output Delivery Against Plan			
Part A: Hospital production. Each DHB is required to submit completed Production Plans as part of the Annual Plan round. From these Production Plans, the Ministry will calculate planned outputs for the following groups of personal health services. 1. Casemix included medical services 2. Casemix included surgical services 3. Casemix included maternity services 4. Non-casemix medical services 5. Non-casemix surgical services 6. ED non-admitted events	3%	Output delivery within three percent of plan	Quarterly
Part B: Monitoring the delivery of personal health services and mental health services For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template. This will be provided by the Ministry, and included with the main quarterly reporting template.	5%	Volume delivery is within five percent of plan	

Developmental – Establishment of baseline (no target/performance expectation is set)		
Performance Measure and description		**Frequency**
DV1: Faster cancer treatment		
Detailed information will be provided in the Ministry of Health's data definitions for the Faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. This information is available on the NSFL website	Data is provided to establish baseline	Quarterly
DV2: Reducing waiting times for diagnostic services		
New measure 2012 - 13	Developmental measure to establish baseline	Quarterly

PHO Performance Programme (Reported Quarterly)

We intend to report the indicators below by PHO and Business Case within DHB of service.

Flu Vaccine Coverage - Total Population	Flu Vaccine Coverage – High Needs
Cervical Cancer Screening Coverage – Total Population	Cervical Cancer Screening Coverage – High Needs
Age Appropriate Vaccinations 2 year olds – Total Pop.	Age Appropriate Vaccinations 2 year olds – High Needs
Breast Cancer Screening Coverage – High Needs	
Ischaemic CVD Detection – Total Population	Ischaemic CVD Detection – High Needs
CVD Risk Assessment – Total Population	CVD Risk Assessment – High Needs
Diabetes Detection – Total Population	Diabetes Detection – High Needs
Diabetes Detection & Follow-up – Total Population	Diabetes Detection & Follow-up – High Needs
Smoking Status Ever Recorded – Total Population	Smoking Status Ever Recorded – High Needs
Brief Advice to Stop Smoking – Total Population	Brief Advice to Stop Smoking – High Needs
Smoking Cessation Support or Referral – Total Pop.	Smoking Cessation Support or Referral – High Needs

Appendix 3. Diabetes Care Improvement Package

Proposal for the Diabetes Care Improvement Package

Introduction

From the 1st July 2012 the Diabetes Get Checked programme is to be replaced with the Diabetes Care Improvement Package (DCIP). DHBs are to use funding currently allocated to the Diabetes Get Checked programme to provide the Diabetes Care Improvement Package which has been planned in consultation with primary care.

This document is a proposal as to how Auckland DHB will utilise funding under the DCIP. There is no nationally consistent model for the DCIP, therefore Auckland DHB, in accordance with Ministry of Health guidance, has jointly developed this with our PHOs; ProCare Networks Ltd, Auckland PHO, Alliance Health + and the National Hauora Coalition. This proposal also includes input from: The Northern Region Diabetes Clinical Network consultation, The Long Term Conditional Quality Reference Group (LTC QRG) and the Primary Care Clinical Advisory Group.

While the free or subsidised element of the annual review is no longer available, GP practices will still be required to continue annual diabetes checks as part of their core diabetes service.

Like other metro Auckland DHB's, ADHB would like to move to an outcomes based contracting framework. As such, 2012/13 year will be a transition year where diabetes annual reviews (which may occur over more than one attendance) will be required to be provided for all people with diabetes.

Traditional mechanisms (such as advanced forms, and Predict) will be used to collect this data to write into the PHO Performance Programme. However the DHB will make a commitment to work with DHBNZ, Ministry of Health and audit tool providers, such as Dr Info, to develop alternate ways of collecting data on the diabetes annual review that can be picked up for all reporting and programme requirements.

Focus Area

Following consultation with PHOs, agreement was reached that the overall aim of the DCIP was to reduce inequalities in diabetes care and management in Auckland DHB. Funding will be focused on Māori, Pacific and Quintile 5 population from 15 years of age onwards.

Justification

Under the Diabetes Get Checked programme, the data showed shows consistently poorer management outcomes, based on HbA1c, for both Māori and Pacific populations. Diabetes cumulative management data for 2011-12 (based on the period July 2011 – March 2012) shows 64% of Pacific people receiving their diabetes annual review have an HbA1c of ≤ 64mmol/mol, 70% of Māori, compared to 84% of Other. See figure 1 that follows.

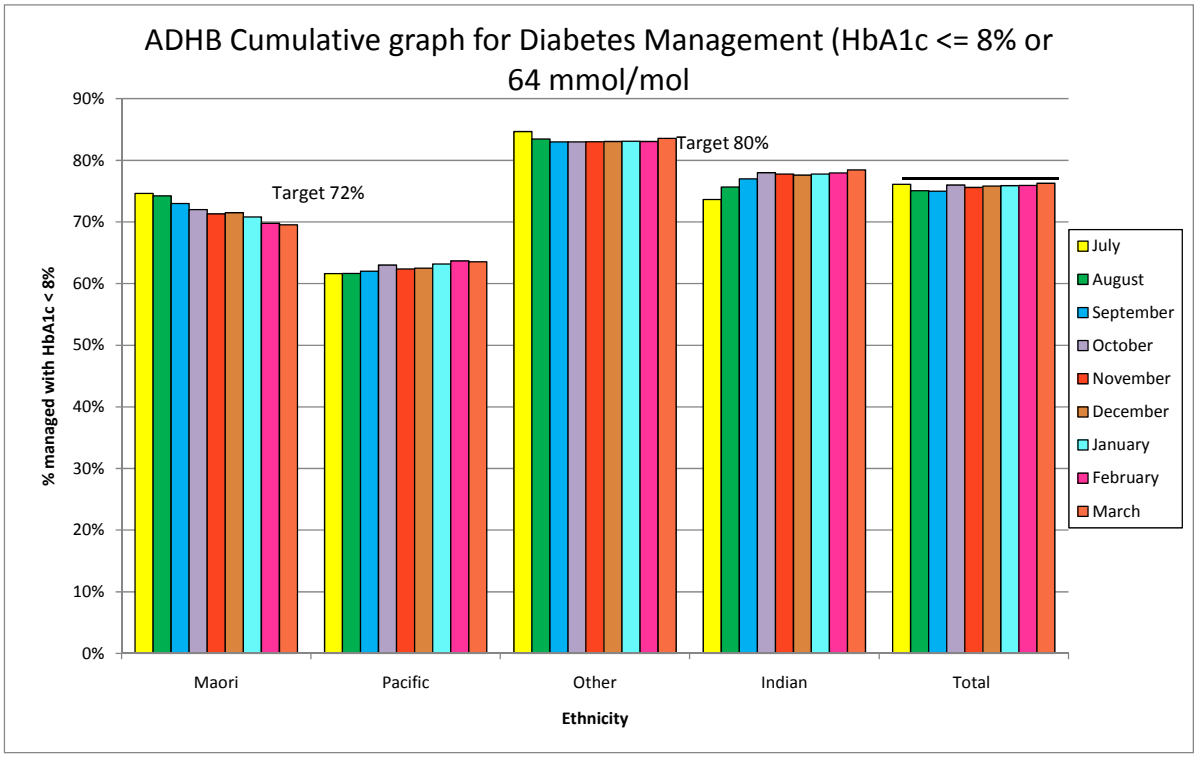


Figure 1: Source: Diabetes Get Checked Programme 2011-12

While the percentage of Māori and Pacific people with good or satisfactory HbA1c (for those accessing their diabetes annual review) has improved over the years, the percentage continues to be well below that of the Other group. By including our Quintile 5 population in the focus area, this enables us to also capture the non- Māori and non-Pacific populations such as some of our South Asian, refugee and homeless populations, who are also disproportionately affected by diabetes. This is also in line with the high needs group targeted under the PHO performance programme.

The diabetes complication rate for ADHB also shows a disproportionate amount of complications occurring in our most deprived population groups. See figure 2 below.

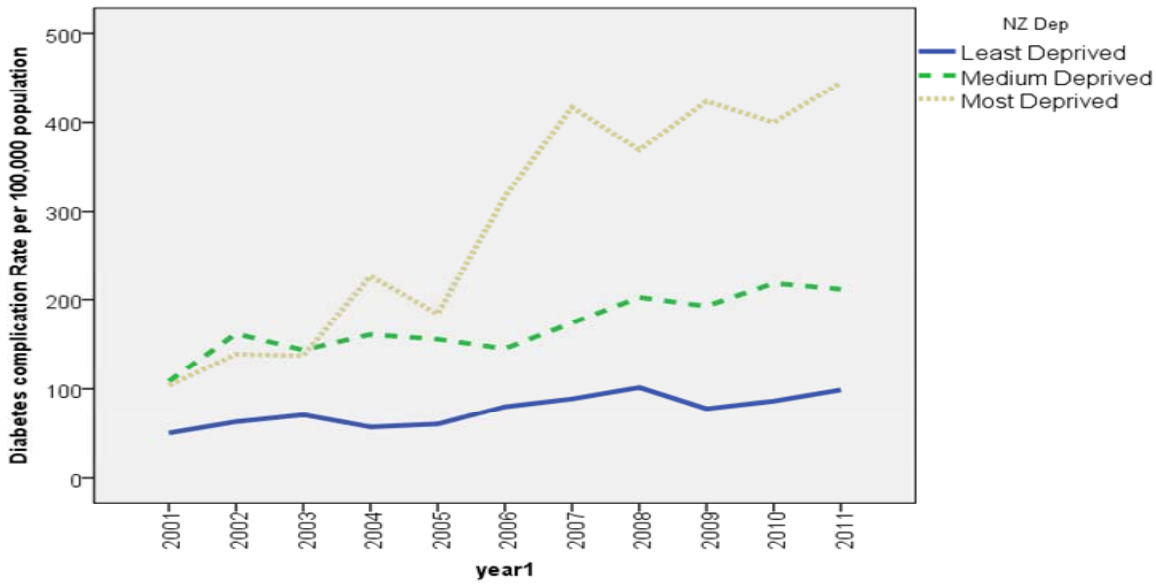


Figure 2: source: National Minimum database 2001-2011

The focus on people greater than 15 years is to focus on the adult population with Type 2 diabetes rather than looking at children, who under 15 years of age, usually have type 1 diabetes and are under the care of the Auckland Diabetes Centre.

With a focus on reducing inequalities in outcomes through targeting primary care services to better engage and deliver services to these population groups, we aim to see an improvement in the measures that have been agreed across all populations, but particularly Māori, Pacific and Q5.

Deliverables to be achieved under the DCIP

To ensure alignment with the Northern Regional Health Plan the indicators for the DCIP will mirror those outlined by the Diabetes Clinical Network. See table 1 below. These Indicators will be reported by PHOs to Auckland DHB on a quarterly basis.

Table 1. Diabetes Indicators

	Indicators	**Prior to Q1**	**2012-13**	**2013-14**	**2014-15**
1	% and number of diabetes patients aged 15-79 that have a diabetes Annual Review This should include assessment of smoking status, BMI, BP, blood tests for renal function, HbA1C, lipids and microalbuminuria, a foot check and be referred for retinal screening (2 yearly)	Establish baseline based on prevalence	60%	tba	tba
2	% and Number of patients aged 15-79 with an HbA1c of 64mmol/mol		76%	80%	tba
3	% and number of patients with diabetes aged 15-79 with diabetes with cardiovascular risk more than 15% on lipid lowering medication	Establish baseline	% increase	% increase	% increase
4	% and Number of patients with diabetes and microalbuminuria or overt nephropathy receiving an ACEI or ARB medication	Establish baseline	% increase	% increase	80%
5	% and Number of patients with systolic blood pressure equal to or more than 140 on blood pressure lowering medication	Establish baseline			
6	% and Number of patients aged 30-79 who have had a CVD risk assessment	60%	75%	90%	90%

**All measures to be broken down by ethnicity (minimum reported ethnicity: Māori, Pacific, South East Asian, Other). The target percentage for each of the measures will be aligned and finalised with the Northern Region Diabetes Clinical Network.*

All PHOs will provide a baseline for each measure prior to Q1, including a distribution of the measures at practice level (which may be anonymous). The improvement on each measure will be set with individual PHOs, with incremental steps to reach an overall agreed target at year 2/3. PHOs will set individual targets with practices. Additional measures may be included for year 2 and out years.

In addition to the above Indicators, the DHB will report the following quarterly indicators to the MOH:

	Indicator	Comment
1	Number of annual reviews conducted for Total and High Needs population	Data captured through PPP
2	Number of practices with a Diabetes Plan for how they are going to improve diabetes care under the DCIP	A template will be provided which can be modified by the PHO or practice. The PHO may also be use this to record practice baseline data against outcome measures and to agree levels of improvement
3	Number of practices achieving their agreed targets for Total and High Needs populations	The PHO will report quarterly on the number of practices that have met the agreed Indicator targets set for that practice
4	Number of practices that have a diabetes register	It will be a prerequisite to contracting under the DCIP that all practices have a population audit tool or mechanism for identifying their population and creating a register of all people with diabetes

How will this be achieved?

It is recognized that each GP practice organizes its diabetes services differently to take account of the different enrolled population needs and therefore the DCIP needs to be designed to take account of this variability. Additionally the DHB understands that each PHO also has its own programmes focused on diabetes and long term conditions and therefore flexibility with this funding enables PHOs to better incentivise practices to achieve these outcomes.

Appendix One contains a timeline of the consultation undertaken and proposed actions.

PHOs have agreed to:

- Collect baseline data for each practice broken down by ethnicity for each of the agreed Indicators
- Agree improvement in Indicators at practice level with a focus on reducing inequalities
- Determine incentives and funding allocation to each practice
- Provide benchmarking to the practices on performance and share best practice and learning's
- Put in place support structures to reduce variability of diabetes outcomes by practice
- Ensure that all practices participate in the DCIP
- Develop a detailed implementation plan and communications strategy to their practices
- Provide the DHB with an action plan on how overall PHO agreed Indicators will be achieved
- Provide the DHB with a distribution of anonymous practice performance against the Indicators

Reporting

PHOs will report to DHBs on the measures (broken down by ethnicity) for Board and Ministry reporting and to the Primary Care Clinical Advisory Group (PCCAG), as below. The reporting format will be agreed with the PHOs. Once the DHB issues contracts with the PHOs on the DCIP, contracts will ensure that quarterly reporting is made available from PHOs to meet the MOH reporting timetable.

The DHB will also receive data on diabetes detection and diabetes follow-up after detection collected through the DHBNZ PHO Performance Programme. This will be made available to the DHB for review, and to discuss and action as required, through the governance groups detailed below.

Governance

The PCCAG, which includes the clinical director of each PHO in Auckland DHB and Waitemata DHB, ADHB planning and funding staff, an epidemiologist, the ADHB Clinical Director, the Clinical Director of Primary Care and the Clinical Director of Primary Care Nursing, will act as the governance structure for the DCIP. This group has been key to shaping the DCIP and is also in the best position to influence performance in primary care practices under the DCIP.

PHOs will be required to report on their DCIP performance at agreed intervals (initially monthly, quarterly once established) to this group, as well as provide an update on any risks meeting the agreed Indicators and provide remedial action plans if required.

The Local Diabetes Team was replaced by a Long Term Conditions Quality Reference Group (LTCQRG) in 2011. This group includes representation from the 4 Auckland PHOs, Diabetes Auckland (who provide a consumer voice), the National Heart Foundation, the Long Term Condition Quality Coordinators, representatives from the Auckland DHB Māori and Pacific Health teams, secondary care diabetes specialists and diabetes nurse specialists, an independent GP and nurse, GP Liaison staff within Auckland DHB, and Long Term Condition Planning and Funding staff. This group will also have performance on the DCIP reported through to them, and will discuss any risks, including mitigation of these, to feedback to their respective PHOs. Through this group, the Long Term Condition Coordinators will be able to target practices requiring further support to reach their Indicators. In some cases members sit on both groups and the links between the two groups are established.

Additionally, there will be some oversight to the DCIP through the Regional Diabetes Network. A decision is also pending as to the merger of planning and funding functions for Waitemata and Auckland DHB, and once confirmed in the new financial year, there may be further joint governance opportunities.

It was not deemed necessary or beneficial to set up a further group tasked with monitoring the DCIP at this stage.

Funding allocation

The DHB has $645,906 of funding from the Diabetes Get Checked programme to invest into the DCIP. This figure was derived from our current expenditure (based on PHO/practice performance forecast for the full year at February 2012, at $45 per diabetes annual review) under the Diabetes Get Checked programme. Funding will allocated to PHOs based on the enrolled PHO population data for Māori, Pacific and Quintile 5 population from 15 years of age onwards.

PHO	Number of practices	Enrolled Population Māori	Enrolled Population Pacific	Enrolled Population Dep 5 (excluding Māori and Pacific)	Total high need enrolled population aged >15 years	Funding per PHO
Alliance Health +	12	2,043	14,443	3,721	20,207	$108,262
Auckland PHO	21	3,114	4,384	5,286	12,784	$68,492
National Hauora Coalition	17	7,707	15,687	8,266	31,660	$169,623
ProCare Networks	88*	11,546	25,354	19,007	55,907	$299,529
Total	138*	24,410	59,868	36,280	120,558	$645,906

** The number of ProCare practices to be included for ADHB in this proposal is still to be confirmed*

If any significant work is required to enable reporting of these Indicators, provision for this resource may need to come from the DCIP funding.

Auckland DHB and the PHOs have agreed that funding will be paid through the PHO to the practice 50% upfront and 50% on achievement of the agreed Indicators. The PHO will set Indicator targets with each practice depending on the practice baseline. The agreed target for the practice to meet will either be a significant improvement or the set target for the Indicator. Once a practice has met the agreed target, the PHO will invoice the DHB for the incentive payment for that practice.

Additional services funded for people with diabetes

Auckland DHB will continue to invest funding to support group self management, retinal screening and provide support to practices through the 3.0FTE Long Term Condition Quality Coordinators.

Group self management education: Auckland DHB currently support the Stanford Chronic Disease self management programme which is being delivered under the Healthy Village Actions Zones (HVAZ) framework. The programme is delivered through the Pacific churches that are part of the HVAZ programme (currently 42 churches are involved in this) by Parish Community Nurses and Community Health Workers. Selected lay church members will also be trained to deliver the programme, with ongoing support, supervision and mentoring from their trainers. Additionally, ADHB funds a Diabetes Self Management Education service across the Auckland DHB area, with a focus on delivering to our high needs community.

Retinal Screening: Auckland DHB provides retinal screening through Greenlane Clinical centre, with community screening coming on board in 2012-13. This will be fixed site screening available at community optometry sites, with greater flexibility around hours of attendance.

Long Term Condition Quality Coordinators: Auckland DHB currently funds 3.0 FTE Long Term Condition Quality Coordinators to work across Auckland DHB to support primary care practices to achieve their diabetes and CVD targets through supporting practices to utilize the tools and guidelines, and use systems and processes to better manage their populations with diabetes, CVD and other long term conditions. The Coordinators will be integral to supporting PHOs and practices to transition from the Diabetes Get Checked programme to meeting the measures under the Diabetes Care Improvement Package.

Risks

In changing the primary service in general practice from the Free Diabetes Annual Review programme to the Diabetes Care Improvement Package we have identified some risks that we will need to manage

Risk	Actions to mitigate risks
Low Diabetes Annual Review (DAR) numbers due to practices not completing required forms	DAR will be a requirement in the DCIP contract with PHOs DAR are still incentivised under PPP Quarterly monitoring of the PHO results Auckland DHB is committed to investigating alternative ways to collect the DAR data
Incomplete Indicator data due to low number of practices with practice audit tools	Prior to Q1, identify the number of practice not using an audit tool Continue to financially support practices to have an audit tool Long Term Condition Coordinators will provide support and training for the audit tool at practice level
Failure of the PHOs to achieve the outcomes for the Diabetes Care Improvement Plan	Monitor service delivery Remedial action plans by PHOs when performance is below required level 50% of funding is based on achieving targets

Timetable

Action	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
MOH announcement DGC programme wound up	X											
ADHB notifies PHOs DGC contracts expire 30.6.12		X										
Northern Region Diabetes Clinical Network consultation on DCIP				X								
Discussion on DCIP with LTC QRG				X		X						
Discussion on DCIP with PCCAG					X	X						
DCIP working group (made up of nominated PHO representatives) agree high level DCIP plan					X							
ADHB/PHO 1:1 Discussion on PHO plan for DCIP							X					
Sign off DCIP by ADHB Adult Health Service Group							X					
PHO provides individual DCIP plan to ADHB							X					
DCIP goes into DAP. Signed off by CPHAC and Board							X					
PHO collect baseline data against each measure for their practices								X				
PHOs implement plan with practices/produce performance plan for each practice								X	X			
Contracts with PHOs developed							X	X				
Contracts signed with PHOs								X				
First quarter report due to MOH												X

Appendix 4. Auckland DHB Board and Management

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

Board members	Jo Agnew	(elected)
	Peter Aitken	(elected)
	Judith Bassett	(elected)
	Susan Buckland	(elected)
	Dr Chris Chambers	(elected)
	Rob Cooper	(appointed)
	Dr Lester Levy, Chair	(appointed)
	Dr Lee Mathias, Deputy Chair	(elected)
	Robyn Northey	(elected)
	Gwen Tepania-Palmer	(appointed)
	Ian Ward	(appointed)

Auckland District Health Board is organised into 6 Integrated Healthcare Service Groups, all led by a Clinical Director. These concentrate the effort of the organisation onto the key priority areas:

- Child Health
- Mental Health and Addictions
- Adult
- Women's Health
- Cardiovascular disease
- Cancer and Blood

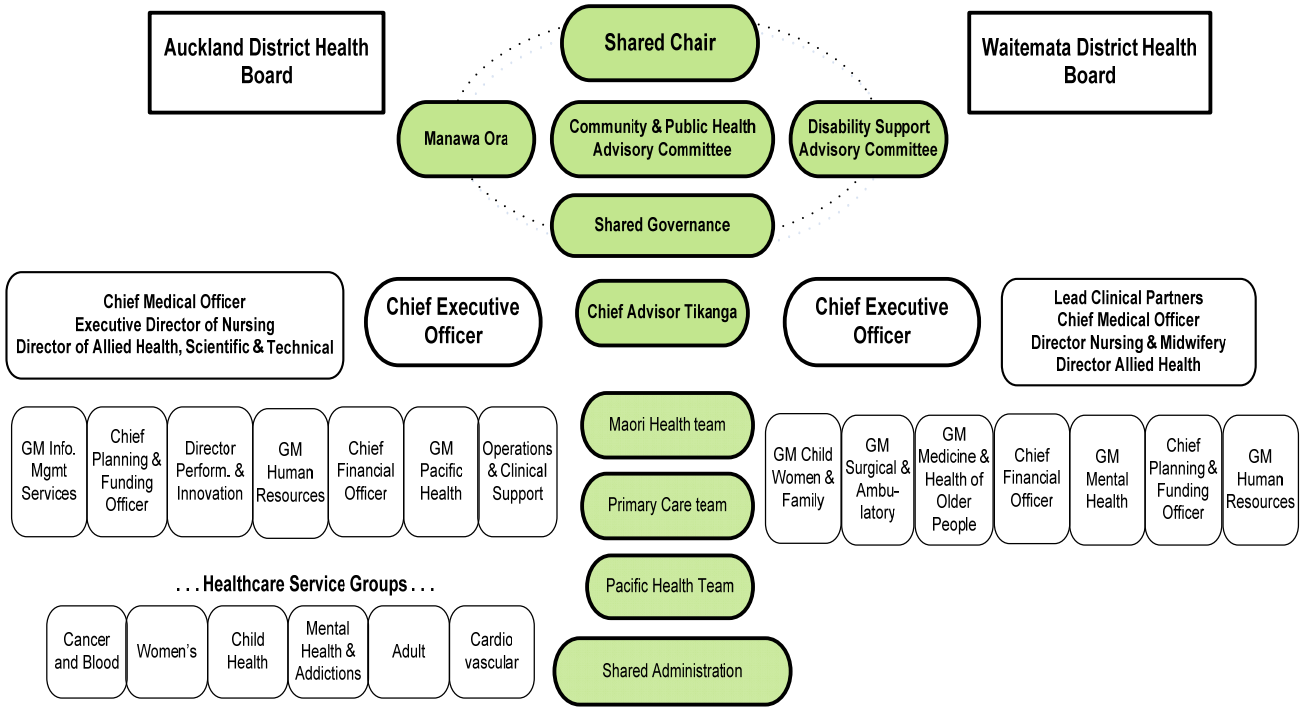
And supported by the Operations and Clinical Support Group

Senior leadership team for Auckland DHB	Dr Margaret Wilsher and Ngaire Buchanan	Joint interim Chief Executive
	Dr Margaret Wilsher	Chief Medical Officer
	Margaret Dotchin	Executive Director of Nursing
	Sue Waters	Executive Director Allied Health, Scientific, & Technical
	Naida Glavish	Chief Advisor Tikanga

Children's Healthcare Service Group	Dr Richard Aickin	Director
	Sarah Little	Nurse Director
	Fionnagh Dougan	General Manager - Starship
Mental Health and Addictions Healthcare Service Group	Dr Clive Bensemann	Director
	Anna Schofield	Nurse Director
	Helen Wood	General Manager (across both ADHB and WDHB)
Adult Healthcare Service Group	Dr Barry Snow	Director
	Margaret Dotchin	Nurse Director
	Andrew Davies	Performance Director
Cardiovascular Healthcare Service Group	Dr Peter Ruygrok	Director
	Peter Lowry	General Manager (Acting)
Women's Healthcare Service Group	Maggie O'Brien	Midwifery Director
	Vacant	Clinical Director
	Vacant	Nurse Director
	Kirsty Walsh	General Manager (Acting)
Cancer and Blood Healthcare Service Group	Dr Richard Sullivan	Director
	Margaret Dotchin	Nurse Director
	Robyn Dunningham	General Manager (Acting)
Operations and Clinical Support	Dr Vanessa Beavis	Clinical Director
	Vacant	Nurse Director
	Ngaire Buchanan	General Manager

Senior team that support activity across the organisation	Dr Ian Civil	Director of Surgery
	Dr Vanessa Beavis	Director Peri-operative Services & Clinical Support Services
	Ngaire Buchanan	General Manager Operations & Clinical Support Services
	Greg Balla	Director Performance and Innovation
	Dr Denis Jury	Chief Planning & Funding Officer
	Aroha Haggie	Māori Health Gain Manager
	Hilda Fa'asalele	General Manager Pacific Health
	Brent Wiseman	Chief Financial Officer
	Linda Wakeling	General Manager, Information Management Services
	Vivienne Rawlings	General Manager Human Resources

Organisational chart for Auckland DHB, showing areas that are merged with Waitemata DHB



Appendix 5. Statement of Intent Measures

Output Class: Prevention Services

Sub-output Class: Health Protection

Measure	Rationale	Baseline◈	Target 2012/13[1]◈	Baseline Info
Outbreaks investigated (demand driven)	Outbreak investigation is an important component of the work of ARPHS and plays a major role in communicable disease control. It is an indicator of the volume of output in this output class. If one assumes that the investigations are conducted effectively, then this should also provide a measure of impact of this service with lower numbers of outbreaks reflecting better disease control generally	1,183 (figure is high due to measles outbreak)	Ω	2011/12
Number of contacts traced in relation to CDC cases (demand driven)	Contact tracing is a substantial component of the work in outbreak investigation. It is therefore a good indicator of the volume of output in this output class	664 [2]	650Ω	2009/10
Communicable disease protocols up-to-date	Communicable disease protocols govern the procedures used for outbreak investigation. Up to date protocols are an indicator of quality	100%	100%	2011
Communicable disease protocols adhered to and in a timely manner	If protocols are up to date and adhered to then it is reasonable to conclude that the quality of work is high	100%	100%	2011
Number of environmental hazard investigations conducted in relation to built environments (demand driven)	Environmental hazard investigation is another important component of health protection. This is an indicator of the volume of output	42	Ω	2011/12

Sub-output Class: Health Protection

Measure	Rationale	Baseline◈	Target 2012/13[1]◈	Baseline Info
Proportion of Hazardous and New Organisms (HSNO) events are responded to appropriately (demand driven)	As with communicable disease protocols, failure to adhere to protocols would indicate problems with quality of the service	100%	100%	2010/11
Proportion of registered water supplier compliance status reports submitted to the Ministry of Health within 20 working days through the Annual Drinking Water Surveillance	There is a clear requirement under that Act to report water supplier compliance within 20 working days. This is a timeliness measure.	100%	100%	2011
Number of emergency response exercises participated in	Exercises and simulations are fundamental to emergency preparedness. This is a measure of the	5	5Ω	2010/11

Measure	Rationale	Baseline◈	Target 2012/13[1]◈	Baseline Info
	volume of output in this component of health protection.			
Number of emergencies responded to (demand driven)	A demand driven indicator of a major component of health protection output.	5	Ω	2011/12 (as at March 2012)
Emergency Plan up-to-date	A failure to keep emergency plans up to date would indicate poor quality output in this area	ARPHS Health Emergency Plan up-to-date	Yes	2011/12
Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border or emergency with inter-district, national or potentially (demand driven)	Prompt reporting of public health events and emergencies indicates the speed and timeliness of response	100%	100%	2010/11

Sub-output Class: Health Promotion

Measure	Rationale	Baseline◈	Target 2012/13[1]◈	Baseline Info
Number of liquor license applications processed by ARPHS and all problematic premises that receive a compliance check	Compliance checks are the principal output which allows us to check that licensees are providing a controlled environment by meeting their host responsibility obligations under the Sale of Liquor Act 1989	82%	100%	2011/12
Alcohol compliance protocols are adhered to when site visits are carried out.	Failure to comply with protocols would reflect a problem with quality.	97%	100%	2011/12
Proportion of liquor licensing applications processed within 15 days	Prompt processing of applications indicates a timely service	100%	100%	2011/12
Proportion of tobacco complaints responded to within 5 days	Prompt response of tobacco complaints indicates a timely service	100%	100%	2011/12

Sub-output Class: Health Policy / Legislation Advocacy and Advice

Measure	Rationale	Baseline◈	Target 2012/131◈	Baseline Info
Numbers of submissions made (demand driven)	Submissions make up a high proportion of this work. The number reflects the volume of output although some involve more work than others	12	15Ω	2011/12
Submissions policy adhered to	Failure to comply with submission policy would indicate a problem with quality	100%	100%	July 2011 – March 2012
Submission documents submitted by deadline	An obvious indicator of timeliness	100%	100%	July 2011 – March 2012

Sub-output Class: Population Based Screening

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Breast screening						
Screening coverage rates among eligible groups: breast cancer	Coverage is a standard measure of output from screening programmes.	*n/a*	67.3%	*n/a*	70%	Total as at Oct 2011
Proportion of women screened who report that their privacy was respected	Reflects the quality of the service	*n/a*	97.5%	*n/a*	95%	2010/11
Proportion of women screened who receive their results within 10 working days	A timely service provides test results promptly	*n/a*	98.3%	*n/a*	90-95%	2010/11
Bowel Screening						
Proportion of eligible population sent an invitation letter each two year screening cycle	Coverage is a standard measure of output from screening programmes.	*n/a*	*New measure*	*n/a*	95%	
Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations.	This indicates whether patients felt that they were able to make an informed decision about colonoscopy and therefore reflects the quality of the service	*n/a*	*New measure*	*n/a*	95%	
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 50 working days	Prompt diagnostics is a timeliness indicator that ensures that screening is performed in a timely way.	*n/a*	*New measure*	*n/a*	95%	
Newborn hearing screening						
Number/proportion of babies screened	Coverage is a standard measure of output from screening programmes	7576 or (95%)	n/a	100%	n/a	Dec 2010 – Nov 2011
Referral rate to audiology <=4%.	Reflects the quality of the service	2%	n/a	<=4%.	n/a	Dec 2010 – Nov 2011
Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme.	A timely service provides prompt access	100%	n/a	>=95%	n/a	Dec 2010 – Nov 2011

Ω Demand driven forecast activity

Output Class: Early Detection and Management

Sub-output Class: Community Referred Testing & Diagnostics

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Number laboratory tests by provider	The no. of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services	*DML = 202,199*	*355,593*	202,200Ω	356,000Ω	2010/11
		LTA = 2,511,224	*2,825,695*	2,520,000 Ω	2,830,000 Ω	
Number community referred radiological procedures	The no. of community referred radiological procedures is a direct indicator of the volume of output of community radiology diagnostic services	47,380	48,839.76 (extrapolated)	Ω	Ω	The volume of radiological procedures referred by GPs to hospital in RVUs (PU code

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
						CS01001) WDHB: Jun-Dec 2011
Complaints as percentage of total no. of laboratory tests ◈	A high quality community laboratory diagnostic service will receive only a small number of complaints	0.00199%		↓		As at Dec 2011
Average waiting time in minutes for a sample of patients attending Waitemata/Auckland DHB collection centres between 7am and 11am (peak collection time)	A high quality service will process patients quickly and efficiently, thereby avoiding long waiting times	7.8 mins	9.15 mins	< 30 mins	< 30 mins	Nov/Dec 11
75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013❖	Timely access to diagnostic testing makes an important contribution to good patient outcomes	65%	57%	75%	75%	As at Jan 2012

Sub-output Class: Oral Health

Measure	Rationale	Baseline		Target 2012 & 2013[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Enrolment rates in children under 5yrs by: Māori Pacific Other Overall	Output is directly related to the proportion of children enrolled in the service	 2,440 4,189 14,017 **20,646**	 4,525 3,158 20,413 **28,096**	**2012** 21,973 **2013** 22,680	**2012** 28,882 **2013** 28,882	2011 calendar year
Utilisation rates for adolescents	This is an indication of the volume of service in relation to the target population	65.7%		**2012** 77% **2013** 85%	**2012** 65% **2013** 85%	2011 interim result
Number of visits of preschool, and school children to oral health services (including adolescents)	Provides an indication of the volume of service.	20,195	14,170	*n/a*	*n/a*	2011 calendar year
Number of complaints for the financial year	A high quality service will receive low numbers of complaints	4	10	↓	↓	2010/11
Arrears rates by ethnicity: Māori Pacific Other Overall	A timely oral health service will have low arrears rates	 18.2% 19.0% 19.5% 19.2%	 16.6% 19.9% 12.2% 13.7%	Overall 2012- 10% 2013- 7%		2011 calendar year

Sub-output Class: Primary Care

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Ethnic-specific primary care enrolment rates	Primary care enrolment rates give an indication of access to primary care health services and differences between ethnicities reflect inequalities in access to primary care	Asian 84% Māori 77%	Asian = 78% Māori = 75%	80% 80%	80% 80%	as at December 2011
Immunisation health target achievement	Preventive health services comprise an important and high impact component of primary care. A high	*New measure – not avail*	*New measure – not avail*	85%	85%	

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
	immunisation rate therefore gives an indication of how well our primary care services are providing preventive health care					
Cervical screening coverage	As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care	73.5%	73.9%	75%	75%	as at September 2011
Numbers of B4 School Checks completed (overall coverage)	Coverage is a standard measure of output from screening programmes	38%	31%	80%	80%	Q2 2011/12
Proportion of practices with cornerstone accreditation	Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. In order to be accredited practices must accurately assess their level of performance in relation to established standards	47%	54%	↑	↑	As at Feb 2012
GMS claims from after-hours providers per 10,000 of population (demand driven)	The utilisation of primary care during weekends provides an indicator of the timeliness of the services available. If availability is low or costs too high then this will be reflected in the utilisation rate	275 per 10,000	426 per 10,000	275Ω	426Ω	2010/11
Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and in the risk of the individuals contracting smoking related diseases	31%	33%	90%	90%	Q3 2011/12
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	Ensuring long-term conditions are identified early and managed appropriately, will help improve the health and disability services people receive and aid in the promotion and protection of good health and independence	45.8%	54.4%	75%	54.4%	Q3 2011/12

Sub-output Class: Pharmacy

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Total value of subsidy provided (demand driven)	This indicates the total DHB contribution towards patients' community drug costs	$127,405,132	$111,263,567	*n/a*	*n/a*	2010/11
Number of prescription items subsidised (demand driven)	Another indicator of overall volume of community pharmacy subsidy to our population	6,275,146	6,158,637	*n/a*	*n/a*	2010/11
Number of Medicine Use Reviews conducted by community pharmacy	Represents the extent to which MUR Services are being utilised to improve medicines adherence in at-risk groups	*n/a*	145	*n/a*	↑	2010/11

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Proportion of prescriptions with a valid NHI number	Represents the extent to which community pharmacists are entering NHI numbers during the dispensing process; this links individuals with dispensing activity to improve data integrity in the national pharms warehouse	96%	97%	100%	100%	2010/11
The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie. any pharmacy open at 8pm on a Sunday)	Represents the accessibility of after-hours pharmacy services to the population	98%	94%	95%	90%	As at Feb 2012

Ω Demand driven forecast activity

Output Class: Intensive Assessment and Treatment

Sub-output Class: Acute Services

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Number of ED attendances (demand driven)	An indicator of the volume of emergency care provided to our population	91,224	97,770	95,000 Ω	100,000 Ω	2010/11
Acute WIES total – provider (demand driven)	An indicator of the volume of acute hospital service provided to our population	92,172.6	98,750.59	↓	↓	2010/11
Readmission rates (demand driven)	Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care	10.24%	10.65%	10%	10.21%	Q2 2011/12
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	Emergency care is urgent by definition, long stays cause overcrowding, negative clinical outcomes and compromised standards of privacy and dignity	95%	92%	95%	95%	Q2 2011/12

Sub-output Class: Maternity

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Number of births (demand driven)	An indicator of volume of service provide to our population	7,523	6,621	Ω	Ω	2010/11
Number of first obstetric consultations (demand driven)	An indicator of volume of service provide to our population	4,410	2,757	4,500 Ω	2,800 Ω	**ADHB** 2011 year **WDHB** 2010/11
Number of subsequent obstetric consults (demand driven)	An indicator of volume of service provide to our population	4,201	2,042	4,200 Ω	2,000 Ω	**ADHB** 2011 year **WDHB** 2010/11

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Proportion of all births delivered by caesarean section	An indicator of volume of service provide to our population	32.6%	26.22%	↓	↓	**ADHB** 2011 year **WDHB** 2010/11
Established breastfeeding at discharge excluding NICU admissions	A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge	81.5%	79.10%	>=80%	75%	**ADHB** 2011 year **WDHB** 2010/11
Third/fourth degree tears for all primaparous vaginal births	Women's Hospital Australasia (WHA) core maternity indicator: 3rd/4th degree tears major complication of vaginal delivery; significant impact on quality of life	4.0%	2.22%	↓	↓	**ADHB** 2011 year **WDHB** 2010/11
Percentage of term elective caesarean performed at >= 39 weeks	Early booking and antenatal care associated with better maternal/foetal health outcomes. If our service is timely and accessible, patients will book at early gestation	47.4%	68.84%	↑	↑	**ADHB** 2011 year **WDHB** 2010/11

Sub-output Class: Elective (Inpatient/ Outpatient)

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Compliance with national health target for surgical discharges	Elective surgery has a major impact on the health status of New Zealanders by reducing disability (e.g. cataract surgery and arthroplasty) and by reducing mortality (e.g. PCI)	11,179	13,786	12,891	15,853	2010/11
Standardised elective surgical intervention rate*	The need for elective surgery varies according to the population composition (e.g. older people require more elective surgery). By standardising our surgical output for our population composition we can assess whether our output is high or low compared to the national norm					2010/11
Joints		12.70 (Joints)	19.08	21	21	
Cataracts		35.45 (Cataracts)	27.93	27	27	
Cardiac		4.81 (Cardiac)	5.44	6.2-6.5	6.2-6.5	
PCR		13.71 (PCR)	19.70	11.9	11.9	
Angio		30.05 (Angio)	39.49	32.3	32.3	
Overall		**282.67 (Overall)**	**281.11**			

** per 10,000 of population*

Sub-output Class: Elective (Inpatient/ Outpatient)

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Number of outpatient first specialist assessment (FSA) consultations (demand driven)	FSA consultations are important component of our elective services output and the total number is a good indicator of the volume of our output	83,210	38,900	Ω	Ω	2010/11

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Patient experience - Percentage of respondents who rate the care and treatment that they receive as 'very good' or 'excellent'	Reflects the quality of the service	82%	*n/a*	90%	*n/a*	Feb 2012
Patients waiting longer than six months for their first specialist assessment (FSA)	Long waiting times for first specialist assessment causes people to suffer conditions longer than necessary, and therefore reflects poor timeliness of the services	0.8%	1.1%	0%	0%	Jan-12
Patients given a commitment to treatment but not treated within six months	If a decision to treat has been made then it can be assumed that the treatment will lead to health gain. The longer a patient waits for this the less benefit s/he will get from the treatment	2.4%	3.0%	0%	0%	Jan-12
Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	Ensuring timely access to cancer treatment for everyone needing it will support public trust in the health and disability system; and that these services can be used with confidence	Chemo 95% Radiation 100%	Chemo 99% Radiation 100%	100%	100%	Q3 2011/12

Sub-output Class: Assessment Treatment and Rehabilitation (Inpatient)

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

Sub-output Class: Mental Health

Measure	Rationale	Age	Eth	Baseline		Target 2012/13[1]		Baseline Info
				ADHB	WDHB	ADHB	WDHB	
Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year)	This indicator demonstrates the utilisation of our mental health services in relation to our population size. Low "Access" rates would indicate that our services may not be reaching a high proportion of those who need them	0-19	Māori	4.21%	3.60%	2.53%	3.60%	Q2 2011/12
			Total	2.35%	2.62%	2.53%	3.0%	
		20-64	Māori	9.55%	7.51%	3.3%	7.50%	
			Total	3.61%	3.43%	3.3%	3.50%	
		65+	Total	3.29%	2.48%			
Proportion of long term clients with Relapse	There is evidence that relapse prevention programmes targeted	Adult	Māori	98.5%	100%	95%	95%	Q2 2011/12
			Pacific	100%	98.61%	95%	95%	

Measure	Rationale	Age	Eth	Baseline		Target 2012/13[1]		Baseline Info
				ADHB	WDHB	ADHB	WDHB	
Prevention Plan (RPP) [target of 95%] in the above population groups (PP-7)	to patients with a high risk of relapse/recurrence who have recovered after antidepressant treatment significantly improves antidepressant adherence and depressive symptom outcomes. The absence of a relapse prevention plan among mental health patients therefore indicates a failing in service quality	Child & Youth	Other Māori Pacific Other	99% 100% 100% 100%	96.08% 93.10% 100% 96.42%	95% 95% 95% 95%	95% 95% 95% 95%	
Alcohol and drug service waiting times and waiting list report (Policy Priorities 8) – waiting times should fall within target for maximum waiting time for each service: • Inpatient detox. • Specialist prescribing • Structured counselling Seen within 3 weeks Seen within 8 weeks	Waiting times for service are an indicator of timeliness. Note: While the national DHB performance measures are 80% and 95%, interim targets are covered on page 117. These are broken down by type of service and by age band.			 61.70% 73.30%	 78.43% 85.21%	 80% 95%	 80% 95%	Oct 2010 – Sept 2011

❖ Note: for WDHB these targets apply to 0-19 and 20-64 year age groups only. For ADHB these targets apply to 20-64 and 65+ year age groups only

Ω Demand driven forecast activity

Output Class: Rehabilitation and Support Services

Sub-output Class: Home Based Support

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Total no. of InterRAI assessments (demand driven)	Simple indicator of output of service	130 per month	n/a	150 per month	n/a	average
The proportion of people aged 65 and older receiving long-term home-support services (who have received HBSS over the last 3 months) who have had a comprehensive clinical assessment and a completed care plan (PP-18)	Good quality, comprehensive and regular assessments will reduce numbers going into residential care and, for older people, services in their own home are much more convenient	New measure	New measure	95%	95%	
Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service.	96%	95%	≥	≥	**WDHB:** Av 2011 **ADHB:** Av: Oct/Nov 11

Palliative Care

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Total number of completed episodes of care (death or discharge) (demand driven)	Inpatient hospice care is the main component off our expenditure on palliative care. Episodes or contacts measure the total	734	n/a	Ω	n/a	April 2011 – March 2012

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
	output from this activity					
Proportion of cancer patients admitted to hospice who are Māori or Pacific versus proportion of cancer deaths who are Māori and Pacific (historical baseline) (demand driven)	Indicator of access equality	**Admissions** M 5% P 12% A 11% **Deaths** M 7% P 11% A 8%	**Admissions** M 9% P 7% **Deaths** M 6% P 4%	% admitted should reflect % deaths by ethnicity	% admitted should reflect % deaths by ethnicity	Hospice **ADHB** Apr 11 – Mar 12 **WDHB** Extrapolated based on 6 mths 2011 2009 cancer death data used for both
Proportion of patients acutely referred who had to wait >48 hours for a hospice bed (demand driven)	Well functioning service should provide timely access for acute patients.	11%	14%	↓	↓	**WDHB** Extrapolated based on 6 months 2011 **ADHB** 2011

Residential Care

Measure	Rationale	Baseline		Target 2012/13[1]		Baseline Info
		ADHB	WDHB	ADHB	WDHB	
Total number of subsidised aged residential care bed days	Bed days are a standard measure of the volume of aged residential care service.	954,667	751,082	≥	≥	**WDHB** 2010/11 **ADHB** Oct 10 – Sep 11
Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year.	Good quality, comprehensive and regular assessments will improve the quality of care received by residents.	*New measure*	*New measure*	20%	20%	
Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service	96%	95%	≥	≥	**WDHB** Average 2011 year **ADHB** Average: Oct/Nov 11

Appendix 6. The Production Plan (Volume Schedule)

2012-2013 planned outputs for Auckland DHB hospital and specialist service

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult-Surgical	General Surgery	Attendance	12464	3192	
		Contact	612	13	
		Cost weighted discharge	8577	2657	
		Implant only		3	
		Written plan of care	200	5	
	Liver Resections	Cost weighted discharge			
	Liver Transplants	Assessment			79
		Attendance	526	729	
		Procedure			50
	Neurosurgery	Attendance	625	1842	
		Cost weighted discharge	1526	4020	
		Written plan of care	96	44	
	Ophthalmology	Attendance	21250	31691	
		Contact	1800	2440	
		Cost weighted discharge	1517	2434	
		Procedure	1934	2853	
		Written plan of care	0	0	
	Oral Health	Attendance	5448	11345	
		Competed treatment	4454	8328	
		Cost weighted discharge	360	776	
		Fitting of a Prosthetic eye	17	64	
		Treatment	1018	1008	
	ORL	Attendance	8109	2951	
		Contact	1054	1360	
		Cost weighted discharge	1273	1586	
		Treatment	0	292	
		Written plan of care	46	0	
	Orthopaedics	Attendance	16108	1161	
		Bed Days	5100	0	
		Cost weighted discharge	8453	1079	
		Service	81970	0	
	Orthotics	Service	143289	96405	
	Renal Transplant	ADHB Defined	0	0	1
		Attendance	124	234	
		Cost weighted discharge	250	506	
	The Auckland Regional Pain Service	Attendance	1053	647	
		Client	34	12	
		Contact	418	197	
	Urology	Attendance	4520	1393	
		Cost weighted discharge	1418	2130	
		Procedure	126	188	
		Written plan of care	343	30	
Adult-Medical	A Plus Links	Assessments	1717	0	
		Attendance	2423	0	
		Client	4705	0	
		Contact	112845	361	
		Hour	9000	0	
	A Plus Links	Occupied bed day	28597	151	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult-Medical		Programme	196424	0	
		Visit	3292	0	
	Critical Care	Service	131386	0	
	Dermatology	Attendance	4365	456	
		Cost weighted discharge	90	41	
		Programme	0	0	
		Treatment	2967	844	
	Diabetes	Attendance	8720	475	
		Client	3383	65	
		Contact	3275	125	
		Procedure	6913	333	
		Service	10	0	
		Written plan of care	221	0	
	Emergency Medicine	Attendance	660	0	
		Cost weighted discharge	2370	614	
		Emergency Department Attendance	14200	4473	
	Endocrinology	Attendance	3260	1980	
		Cost weighted discharge	70	98	
		Test	2440	302	
	Gastroenterology	Attendance	8460	762	
		Cost weighted discharge	736	106	
		Procedure	87	20	
		Test	57	18	
	General Medicine	Attendance	1220	38	
		Cost weighted discharge	9250	366	
	Immunology	Attendance	1730	2784	
		Contact	54	27	
		Cost weighted discharge	204	294	
		Treatment	0	0	
		Written plan of care	0		
	Infectious Diseases	Attendance	1538	942	
		Cost weighted discharge	207	110	
		Service	120178	402115	
		Written plan of care	80	16	
	Needs Assessment, Service Coordination	Assessment	9100	0	
		Hour	4800	0	
		Programme	1169600	0	
		Service	1	0	
	Neurology	Attendance	2608	5452	
		Cost weighted discharge	1055	757	
		Procedure	0	0	
		Programme	180720	0	
		Test	85	1166	
		Written plan of care	365	1058	
Adult-Medical	Rehab Plus	Attendance	3594	0	
		Day Attendance	812	0	
		Occupied bed day	8120	0	
		Visit	3537	0	
	Renal Medicine	Attendance	36635	6570	
		Cost weighted discharge	1120	551	
		New client	42	1	
		Patient	1028	22	
		Service	108634	46639	
		Written plan of care	22	0	
	Respiratory Medicine	Adjuster	61623	95069	
		Assessment	0	0	38
		Attendance	5985	3031	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult-Medical		Client	1554	2100	
		Contact	1730	35	
		Cost weighted discharge	2090	981	
		Procedures	167	104	
		Programme	0	0	11
		Service	0	0	
		Test	590	298	
		Written plan of care	0		
	Rheumatology	Attendance	4045	61	
		Cost weighted discharge	100	5	
	Sexual Health	Contact	9212	13619	
		Service	777639	1318507	
Cancer	Haematology	Adjuster	114764	695754	
		Attendance	10451	8013	
		Cost weighted discharge	850	1680	
		Programme	2216134	1497539	
		Written plan of care	135	7	
	Oncology	Attendance	24198	73954	
		Cost weighted discharge	920	2160	
		Programme	3445431	7319382	
	Palliative Care	Programme	452565	0	
Cardiac	Cardiology	Assessment	0	0	48
		Attendance	7619	1064	
		Client	600	3	
		Cost weighted discharge	3617	4065	
		Implant only	0	0	
		Locally Defined	289752	0	
		Programme	150357	0	15
		Test	3308	564	
		Written plan of care	160	36	
	Cardiothoracic	Attendance	184	526	
		Cost weighted discharge	2806	8927	
	Donor Coord	Programme	0	0	2
	Vascular Surgery Vascular Surgery	Attendance Cost weighted discharge	2013 1156	2569 2464	
Children's	Adult Congenital Heart	Attendance	0	0	791
		Cost weighted discharge	0	0	350
	Audiology	Test	4886	3093	
	Child Health & Disability	Adjuster	140032	0	
		Client	304234	0	
		Contact	1763	0	
		Programme	788830	0	
		Service	353819	0	
		Test	546130	0	
	General Paediatrics	Attendance	11730	398	
		Cost weighted discharge	1500	1701	
		Programme	1536	0	
	Newborn Services	Attendance	500	654	
		Cost weighted discharge	2020	1559	
		Service	319285	0	
	Paediatric Cardiac	Attendance	0	0	3291
		Cost weighted discharge	0	0	4298
		Procedure			187404
		Written plan of care	0	0	684
	Paediatric Dermatology	Attendance	408	462	
	Paediatric Developmental Neurology	Attendance	1171	16	
	Paediatric Emergency Department	Attendance	0	0	
		Cost weighted discharge	1003	687	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
		Emergency Department Attendance	20425	5769	
Children's	Paediatric Endocrinology	Attendance	965	2559	
		Client	103	407	
		Cost weighted discharge	50	125	
		Service	9	2	
	Paediatric Family Information Service	Service	63000	204791	
	Paediatric Family Options	Service	83000	286004	
	Paediatric Gastroenterology	Attendance	233	894	
		Cost weighted discharge	73	560	
	Paediatric Haem/Onc	Adjuster	143471	1035277	
		Attendance	1561	7318	
		Cost weighted discharge	341	1319	
		Programme	320086	1732440	
	Paediatric Home Health Care	Service	25409	14813	
	Paediatric Immunology	Attendance	343	523	
		Cost weighted discharge	36	99	
		Treatment	0	0	
	Paediatric Infectious Diseases	Attendance	185	362	
Children's		Cost weighted discharge	56	61	
	Paediatric Intensive Care Unit	Service	0	0	
	Paediatric Metabolic	Attendance	0	0	1568
		Contact	0	0	936
		Event	0	0	179
		Programme			62500
	Paediatric Neurology	Attendance	608	1773	
		Cost weighted discharge	125	547	
		Written plan of care	0	0	
	Paediatric Neurosurgery	Attendance	94	442	
		Cost weighted discharge	136	1198	
		Written plan of care	0	147	
	Paediatric ORL	Attendance	4282	1856	
		Cost weighted discharge	717	890	
	Paediatric Orthopaedics	Assessment	11	85	
		Attendance	3914	6505	
		Cost weighted discharge	1018	2589	
	Paediatric Pain Service	Attendance	118	204	
		Cost weighted discharge	0	2	
	Paediatric Palliative Care	Attendance	124071	243283	
	Paediatric Renal Medicine	Attendance	323	516	
		Cost weighted discharge	28	273	
		New client	0	0	
		Patient	18	76	
	Paediatric Respiratory Medicine	Attendance	362	1091	
		Client	14	136	
		Cost weighted discharge	180	842	
		Test	33	2	
	Paediatric Rheumatology	Attendance	140	636	
		Cost weighted discharge	24	71	
		Programme	0	0	1
Children's	Paediatric Surgery	Attendance	1297	3451	
		Contact	0	0	
		Cost weighted discharge	841	2700	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
	Whakaruruhau	Service	416484	1134872	
Operations and Clinical Support	Adult Allied Health	Contact	7850	2628	
	Clinical Infectious Diseases	Test	133993	672682	
	Elective Services	ADHB Defined	227307	0	
		Service	330712	0	
	Emergency Management Service	Programme	367118		
	Imaging	Attendance	75	317	
		Relative Value Unit	33250	11987	
Operations and Clinical Support	Labs	Service	5157420	11372547	
	Metabolic Service	Programme	0	0	229575
	Nutrition	Contact	5890	5450	
	Women's & Child Allied Health	Contact	3539	3843	
Women's Health Service	Fertility Plus	Attendance	210	271	
		Client	38	36	
		Prescription	33749	81777	
		Procedure	388	748	
		Service	31	87	
	Genetics	Attendance	0	0	2452
		Event	0		351
		Service	0	0	
		Written plan of care			119
	Gynaecology	Attendance	8204	3050	
		Cost weighted discharge	2547	784	
		Procedure	2090	3844	
		Procedures	50	0	
		Written plan of care	1532	75	
	Obstetrics	ADHB Defined	0	0	
		Attendance	10039	6613	
		Client	330	321	
		Contact	21033	4055	
		Cost weighted discharge	5570	2603	
		Written plan of care	0	0	

Appendix 7. Statement of Accounting Policies

This is a summarised description of the accounting policies used in the preparation of this Annual Plan. A full description of accounting policies used by Auckland DHB for financial reporting, budgeting and forecasting can be found in the 2010 Annual Report on the website at www.adhb.govt.nz/publications.

Reporting entity: The reporting entity is the Auckland District Health Board (ADHB) which was created by the New Zealand Public Health and Disability Act 2000. Auckland DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 (and the 2010 amendment), the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Auckland DHB is a public benefit entity (PBE), as defined under NZ IAS 1: 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.

Statement of compliance: The Consolidated Financial Statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for Public Benefit Entities (PBE).

Basis of preparation: The financial statements are presented in New Zealand Dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on the historical cost basis except that the following asset and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swaps), financial instruments and land and buildings.

The preparation of financial statements in conformity with NZ IFRSs requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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.
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 shareholdings in the following associates: Auckland Regional RMO Services Limited (previously The Northern Clinical Training Network Limited) (33% owned), Northern DHB Support Agency Limited (33% owned) and healthAlliance NZ Limited (20%). Auckland Regional RMO Services Limited is a joint venture company with Counties-Manukau and Waitemata DHBs, which exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs. Northern DHB Support Agency Limited with Counties-Manukau and Waitemata DHB exists to provide a shared services agency to the three Auckland regional DHB boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution. healthAlliance NZ Limited is a joint venture company with Health Benefits Limited and Counties-Manukau, Northland and Waitemata DHBs that exists to provide a shared services agency to the four northern DHBs in respect to information technology, procurement and financial processing.

Transactions eliminated on consolidation: All inter-entity transactions are eliminated on consolidation.

Foreign currency: Both the functional and presentation currency of Auckland DHB and Group is in NZD. Transactions in foreign currencies are translated at the exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at balance date are translated to NZD at the rate ruling at that date.

Budget figures: The budget figures are those approved by the Board in its Annual Plan and included in the Statement of Intent tabled in Parliament.

Equity: Equity comprises contributions from the Crown, accumulated surpluses/deficits and reserves. Crown contributions are recognised at the amount received, accumulated surpluses/deficits in accordance with the financial results using generally accepted accounting principles, and reserves from changes in the value of land and buildings.

Property, plant and equipment (PPE): The major classes of property, plant and equipment are as follows: freehold land; freehold buildings and fitouts; plant, equipment and vehicles; leased assets; and work in progress

Owned assets	Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses. Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to

fair value, and at least every five years. The latest revaluation was done on 30 June 2011.

Additions to PPE between valuations are recorded at cost.

Disposal of property, plant and equipment

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

Leased assets

Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases.

Operating lease payments are recorded as an expense in the Statement of Financial Performance on a straight-line basis over the lease term.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to Auckland DHB. All other costs are recognised in the Statement of Financial Performance as an expense as incurred.

Depreciation

Depreciation is charged to the Statement of Financial Performance using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair value of the assets, less their estimated residual values, over their useful lives, as follows:

Asset class	Useful lives
Freehold buildings and fitouts	1–89 years
Plant, equipment and vehicles	2–20 years
Lease assets	4–8 years

The residual value, useful life and depreciation method of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to property, plant and equipment on its completion and then depreciated.

Intangible assets: Computer software not an integral part of the related hardware is treated as an intangible asset. Such intangible assets are acquired separately and are capitalised at cost less accumulated amortisation and impairment losses.

Interest-bearing loans and borrowings: Interest-bearing capital bonds are measured at amortised cost using the effective interest method. Amortised cost is calculated by taking into account any issue costs, and any discount or premium on settlement. Crown Health Financing Agency borrowings are recorded at nominal or "face" value.

Derivative financial instruments: Auckland DHB uses foreign exchange and interest rate swap contracts to manage its exposure to foreign exchange and interest rate risks arising from operational, financing and investment activities. Such derivatives are accounted for as trading instruments, and are stated at fair value.

Trade and other receivables: These are recognised and carried at original invoice amount less impairment. Bad debts are written off during the period in which they are identified.

Inventories: All items are valued at the lower of cost, determined on a first-in first-out basis, and net realisable value. A provision for slow moving or obsolete stock is made.

Cash and cash equivalents: Cash and cash equivalents comprise cash and call deposits with an original maturity of less than three months. Bank overdrafts that are repayable on demand and form an integral part of Auckland DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Assets held for sale: Properties held for sale are measured at the lower of carrying amount or fair value less costs to sell.

Impairment of financial assets: The carrying amounts of financial assets are reviewed at balance date to determine whether there is any indication of impairment. Impairment losses are recognised in the Statement of Financial Performance.

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

Employee benefits

- **Defined Contribution Plan (DCP):** Obligations for contributions to Defined Contribution Plans are recognised as an expense in the Statement of Financial Performance as incurred
- **Retiring Gratuities and Long Service Leave:** Auckland DHB's net obligation in respect of Retiring Gratuities and Long Service Leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods calculated on an actuarial basis

Annual leave, sick leave, continuing medical education leave and expenses

- **Annual leave** is a short-term obligation and is calculated on an actual basis at the amount Auckland DHB expects to pay when staff take leave or resign.
- **Sick leave** is a short-term obligation which represents the estimated future cost of sick leave attributable to the entitlement not used at balance date calculated as the amount expected to be paid.

Continuing medical education leave and expenses are calculated based on a discounted valuation of the estimated three years non-vesting entitlement under the current collective agreement with Senior Medical Officers based on current leave patterns.

Provisions: A provision is recognised when Auckland DHB has a present obligation (legal or constructive) as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and a reliable estimate can be made. If the time-value of money is material the obligation is discounted to its present value.

Restructuring: a provision for restructuring is recognised when Auckland DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly.

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

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

Auckland DHB is required to recognise and expend all monies appropriated within certain contracts, e.g., the mental health ring-fence on mental health services, during the year in which it was appropriated. Should this not be done such revenue, with the agreement of the funder, is included in Payables and Accruals in the Statement of Financial Position until the time this obligation is discharged.

Trust and special fund donations received are treated as revenue on receipt, in the Statement of Financial Performance. These funds are administered by the Auckland District Health Board Charitable Trust. Interest income is recognised using the effective interest method.

Goods and services tax (GST): All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST.

Borrowing costs: Borrowing costs are recognised as an expense when incurred.

Cost allocation: Auckland DHB has arrived at the net cost of service for each significant activity using the cost allocation system below:

- **Cost allocation policy:** Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
- **Criteria for direct and indirect costs**: Direct costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost drivers for allocation of indirect costs: The cost of internal services not directly charged to outputs is held in central overhead pools, for example, the cost of building accommodation. The exceptions to this are ring-fenced services Mental Health and Public Health where an allocation of overheads is made, and some services that sell to third parties, for example LabPlus.

Key lenders

Key lenders and applicable covenants	
Key lenders	**Covenants to all lenders**
Westpac Crown Health Financing Agency Bonds on issue	Cashflow from operations greater than zero Debt to debt + equity less than 65%

Key lenders and arrangements	
Bonds	$50 million due 2015
Crown Health Funding Agency	$254.5 million term advances facility
Commonwealth Bank of Australia	$65 million working capital facility

Asset Disposals

Auckland DHB actively reviews assets to ensure that it has no surplus assets. No significant assets are scheduled for disposal during the plan period. Some minor asset disposals will occur as part of the regular capital replacement programme.

Disposal of Land

The disposal process is governed by various legislative and policy requirements, the essence of which is described below.

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