AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

2015/16 Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Auckland District Health Board

Mihimihi

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

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

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

Auckland District Health Board Annual Plan 2015/16

The Auckland District Health Board Annual Plan for 2015/16 is signed for and on behalf of:

Auckland District Health Board

Dr Lester Levy, CNZM
Chairman

Dr Lee Mathias, ONZM
Deputy Chairman

Ailsa Claire
Chief Executive

Our Te Tiriti o Waitangi partners
Te Runanga o Ngati Whatua

ONZM JP

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

And signed on behalf of:

The Crown

17/9/15

Hon Dr Jonathan Coleman
Minister of Health

Date

Office of Hon Dr Jonathan Coleman

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

25 SEP 2015

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

Dear Dr Levy

Auckland District Health Board 2015/16 Annual Plan

This letter is to advise you I have approved and signed Auckland District Health Board's (DHB's) 2015/16 Annual Plan for one year.

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

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to 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 DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where

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these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets

Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I expect all DHBs to make continued progress on this target to ensure that we meet the achievement level by next July.

System Integration

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Auckland DHB plans to maintain current levels of primary care access to radiology and Primary Options for Acute Care, and intends to strengthen integration in 2015/16 by:

- developing an interdisciplinary and integrated model of care, including shifting services, with general practice and community services by September 2015 with implementation by June 2016
- developing a mental health clinical pathway by December 2015 with implementation in March 2016
- improving access to cognitive impairment and infusion services by December 2015 and March 2016
- developing a work plan to improve access to podiatry and retinal screening by September 2015 with implementation by June 2016.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders

Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity

I am pleased to note your Annual Plan includes a focus on obesity and identified a range of activities to tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be

meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

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 National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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

The Statement of Intent covers the four year period: 1 July 2015 to 30 June 2019.

Foreword from the Chair and Chief Executive

Themes critical to the work of Auckland DHB through to 2020 include:

- Our population, patients and whānau are central to our thinking, decision making and accountability
- Getting the best outcomes from our resources
- Elevating quality and safety (including workplace safety)
- Collaboration, innovation and high quality communication
- Holding people, systems and structures to account

The work covered by these themes is not new, nor is it the exclusive concern of Auckland DHB. What is unique to Auckland DHB is the way we will do this work, through an emergent approach which enables our population, patients and staff.

Our plan is to work with people in a way that will make the healthcare and treatment options they receive more personal and over time, this approach will see our local population become more involved in promoting their own health and that of their families. More health-related activity will be provided in the community, which has the potential to translate into fewer unnecessary hospital admissions and in turn any reduced demand on hospital services will help manage the growth in costs associated with hospital based treatment.

Our strategy reinforces the need for the health system to be joined up across the continuum of health. The future lies in innovation and collaboration, which in itself presents a significant challenge. Enhanced innovation and collaboration will help do more in settings outside the hospital where we can promote health and manage problems at the earliest stage. Our programme of work with primary health will become more critical, especially ensuring that primary and community-based staff are able to draw on the skill of hospital-based clinicians.

Some groups in our district face real hardship and these are the people we see in hospital most often. All people living in our Auckland district should have an equal opportunity to live a long, healthy life, regardless of their level of income, education or ethnicity. Our health interventions need to be prioritised towards people with the greatest need.

We already provide some world-class health services in our hospitals and if we are to meet our aspirations in 2020 we will need to think critically about the design and delivery of our services and we will also need to be bold in our innovations.

We need to ensure that all of Auckland DHB's activities are provided within budget, while being safe, of high quality and effective. In 2015/16 we will need to be much clearer about the scope and cost of the treatment and training services we provide to other DHBs and match this to the funding available. This financial imperative cannot be solved by efficiency programmes alone – work that is empowering and patient-centred will help to reduce the 'cost curve' over time.

As a public entity, and one of the largest employers in the country, we also need to be a good employer, to minimise waste and use all resources prudently. Programmes to achieve this are underway, as well as a very strong focus on workplace safety – we need to ensure that our patients, staff, visitors, contractors and sub-contractors are all as safe as possible.

The challenges we face continue to be both significant and urgent, but we are building on great strengths and a strong sector wide commitment to support the populations of Auckland and New Zealand to maximise their

health and wellbeing. We would like to thank all of our staff, we are greatly appreciative of all of their hard work and commitment.

Dr Lester Levy
Chairman
Auckland District Health Board

Ailsa Claire
Chief Executive
Auckland District Health Board

Te Tiriti o Waitangi

Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the relationship between the Crown and Iwi. It provides a framework for Māori development and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

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

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

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

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

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

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

Whānau ora

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

Auckland DHB

Who we are and what we do

The Auckland District Health Board is one of 20 District Health Boards established under the Health and Disability Act 2000. The Auckland DHB is the government's funder and provider of health services to the 478,000 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier.

Auckland DHB receives funding from the government with which to purchase and provide health and disability services to the population within our district. The objectives of DHBs are outlined within the Health and Disability Act 2000. These objectives include:

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

To achieve these objectives, the Auckland DHB works with consumers, stakeholders and communities and other health and disability organisations to plan and co-ordinate activities, monitor and report on the health status of the population and health system performance, foster health promotion and disease prevention, and ensure provision of high quality and equitable health and disability services.

DHBs have four key roles to deliver on their objectives under the Health and Disability Act 2000. DHBs act as 'planners', 'funders' and 'providers' of health services, as well as owners of Crown assets. Each DHB's Planning, Funding and Outcomes Division is responsible for assessing its population's health need and determining the mix and range of services to be purchased within the available funding and specific financial constraints. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus within our district. The identified needs are then balanced alongside national and regional priorities. These processes inform the Northern Region Health Plan, which sets the longer-term priorities for DHBs in the northern region (i.e. the Northland, Waitemata, Counties Manukau and Auckland DHBs), this annual plan and the Auckland DHB's Māori Health Plan.

The Auckland DHB provides specialist hospital and community health services to people living in our district and to people from other parts of New Zealand. Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. Other services provided by Auckland DHB include community child and adolescent health and disability services, community mental health services and district nursing. The Auckland DHB is unique in that is provides specialist services not available within other DHBs. We are a major academic facility and carry a large training and research role for the country. Being a tertiary and national centre puts pressure on resources and on our ability to serve our population.

Our population at a glance

Analysing the demographics and health profile of our district[1] helps us understand our population. Predicting the demand for health services helps us to allocate resources where they are most needed. Understanding our population also shows us where inequalities persistent in health outcomes and in the access that some population groups have to health and disability services.

Our population is diverse and growing

- The Auckland DHB serves approximately 478,000 people, making it the fourth largest population of all of New Zealand's DHBs
- We have an ethnically diverse population, with 8.3% Māori, 11% Pacific, 29% Asian and the remainder being European/Other
- Our region contains a large migrant population, with two out of five individuals born overseas
- Auckland has a similar socioeconomic deprivation profile to New Zealand as a whole. Almost one in five (19%) of our total population live in the poorest areas (NZDep13 decile 9 and 10) and 23% of our population live in areas of the two wealthiest deciles
- Significant population growth is expected in the future, as our population is projected to increase by a third, reaching 610,000 by 2034
- Our population is ageing, with the number of people aged 65 years and older expected to nearly double by 2034, increasing from the current 50,000 to 96,000

Our population is healthy and health is improving

- The average life expectancy in Auckland is 83 years, similar to that observed nationally and increases by an average of 2.6 years per decade
- Our mortality rates from cardiovascular disease and cancer, the two biggest causes of avoidable deaths, have declined steadily over the last decade
- The children in our district experience a great start to life with a much lower rate of infant mortality (3.2 per 1,000 live births) than that observed nationally (5.2 per 1,000 live births), with very high rates of immunisation
- Smoking rates in adults have declined from 16.5% in 2006 to 11% in 2013, and is the lowest of any DHB

Challenges for our district

Although the majority of our population enjoy very good health, we continue to face a number of challenges as both a provider and funder of health services and for the health status of our population.

Our 2014 assessment of health need highlighted areas where improvements are needed in the health status of our population. Many of these areas are not unique to our DHB, but we must understand what they mean for our population and which ones should be addressed with urgency.

People are dying of preventable diseases - Healthier lifestyles can prevent deaths and illness. Health services play a key role in supporting people to stop smoking, eat healthily and to exercise more.

We need to get tough on the big problems - Everything we do is important but it cannot all be a priority. Too many priorities mean we do not make headway on the killer diseases. By prioritising our resources, we

[1] Please refer to our website: www.adhb.govt.nz for our full Health Needs Assessment undertaken in 2014

can drive down rates of heart disease, stroke, diabetes, cancer and mental health problems. Excellence requires investment in research and in academic collaborations.

The responsibility for good health needs to be shared - An increased focus on prevention and early intervention can prevent or delay the onset of disease and this means working with other agencies.

More attention on the young and the old - Ensuring positive health outcomes for children, young people and mothers are essential for positive long-term health outcomes for our population. Risk and protective factors and social patterns established in childhood and adolescence have a significant impact on long-term health. More help is also needed to help people stay healthy as they age.

We have persistent inequities in health status - We need to be bolder in our actions to achieve equitable health outcomes across the system.

We lack a common purpose - We have over 10,000 staff with a tremendous diversity of skill and culture. We need to develop our people and establish a culture that lives our values.

More health services are needed in the community, specifically in primary care - The health system is overly focused on the hospital. More services could be provided close to where people live, work and play.

Tertiary and quaternary services are essential but expensive - As a hospital of last resort, Auckland carries the greatest burden for the cost of specialist work. Our hospital services must be sustainable over time.

Key areas of risk and opportunity

The following risks and opportunities are relevant for 2015/16.

Risks	Mitigations/opportunities
Meeting future health needs and the growing demand for health services	Maintaining momentum in key areas, such as: • Upstream interventions that improve the social and economic determinants of health, both within and outside of the health system • Improved patient-focused and empowering models of care • Ensuring the best management of long-term conditions • Integrating services (the coordination of care, systems and information) and working as a whole system to better meet people's needs • Working regionally and across the government and other services to address health and other priorities
Changing population demographics	• Engaging patients, consumers, their families, and the community in the development and design of health services and ensuring that our services are responsive to their needs • Assisting people and their families to manage their own health in their own home, supported by specialist services delivered in community settings as well as hospitals, and increasing our focus on proven preventative measures and earlier intervention
Ensuring long-term sustainability through fiscal responsibility	• Ongoing commitment to achieving a breakeven financial position • Implementation of identified performance improvement and efficiency initiatives • Effective governance and strong clinical leadership • Connecting the health system through improved integration and regional collaboration to support improved national, regional and local service delivery models of care • Delivering the best evidence-based care to avoid financial and system waste • Ensuring tight cost control to limit the rate of cost growth pressure

Te Toka Tumai: a strategy to 2020

In 2014, we began work on a strategy that would set the direction to 2020. The critical themes in the strategy recognise how personal health and wellbeing is. Each individual has different experiences and aspirations for their health and wellbeing. Our responsibility is to help people achieve the outcomes that matter to them, their whānau and communities. We need to deliver health and disability services where people live, learn, work and play.

Te Toka Tumai is the Māori term for the Auckland DHB. It refers to the rock that stands firm in the sea of the Waitemata harbour of Tamaki Makaurau (Auckland). The rock reminds us that the health system needs to be a solid whole, where all of the activities across the continuum of health and disability are joined as one. *Te Toka Tumai* is our proud and dependable foundation when the going is tough.

Te Toka Tumai: our direction at a glance

Our Vision	Healthy communities – World-class healthcare – Achieved together *Kia kotahi te Oranga mo te iti me te Rahi o Te Ao*				
NZ Triple Aim	Improved health and equity for all populations		Improved quality, safety and experience of care		Best value for public health system resources
Strategic Priorities	Our population, patients and whānau are central to our thinking, decision making and accountability	Getting the best outcomes from our resources	Elevating quality and safety (including workplace safety)	Collaboration, innovation and high quality communication	Holding people, systems and structures to account
Action across four settings	 Home	 Locality	 Community services		 Hospital
	– *because good health and wellbeing happens where people live, learn, work and play* –				
Key Result Areas	Improved Health Status	Economic Sustainability	Patient Safety	Healthy and Engaged Workforce	Better Quality and Experience of Care
Our Values	Welcome - Haere Mai *We see you and welcome you as a person*	Respect - Manaaki *We respect, nurture and care for each other*	Together - Tuhono *We are a high performing; colleagues, patients and families*		Aim high - Angamua *We aspire to excellence and the safest care*
Our Purpose	Enabling health and wellbeing through high-quality health and disability services and a commitment to innovation, education and research				

Vision and values

Our organisation's vision and values underpin our work as a provider and funder of health and disability services.

Our vision is: **Healthy communities, world-class healthcare, achieved together**
Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

We will create healthy communities by helping people achieve the health outcomes that matter to them, their whānau and communities. We will provide world-class healthcare through a health system that places people, patients and whānau at the centre.

After extensive staff and patient engagement, we have developed a set of values.

Welcome *Haere Mai*	**Respect** *Manaaki*	**Together** *Tuhono*	**Aim high** *Angamua*
We see you and welcome you as a person	*We respect, nurture and care for each other*	*We are a high performing team with colleagues, patients and families*	*We aspire to excellence and the safest care*

A behaviour framework sits alongside these values as a guide to putting the values into action.

Critical themes

The most pressing of our challenges will be addressed via a focus on the following:

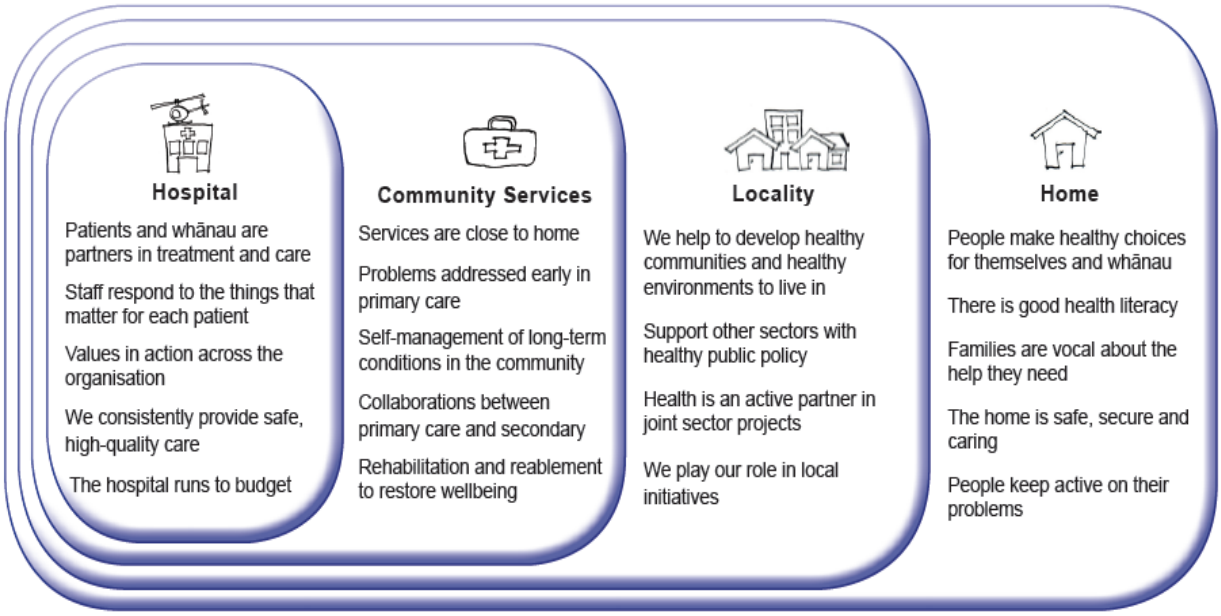
Strategic priorities	What this means
Our population, patients and whānau are central to our thinking, decision making and accountability	Our values compel us to work mindfully with patients, communities and our colleagues. We make time to stop, listen and hear what matters to each person. We need a system that supports people to achieve the goals that matter to them. We will also be active in supporting people towards healthier lifestyles. We will place more attention on keeping people well at the beginning and the end of life. This means a focus on the young and the old.
Getting the best outcomes from our resources	Many of our resource-related issues are sector-wide issues. We must achieve more with every dollar we get from government and this pressure is likely to increase in the future. We need to work with others to develop the best mix and configuration of specialist work for our region and the country. To get the best outcomes from resources, we need to focus on the major causes of ill health. People who are unwell need to be assured of timely and efficient access to services.
Elevating quality and safety	Overall, the Auckland DHB has a very specialised and skilled workforce that provides excellent clinical services. We can do better in the future by improving the use of the data we collect and by working together across the health system.

Strategic priorities	What this means
Collaboration, innovation and high quality communication	The health system needs to be joined across the continuum of health. Enhanced innovation and collaboration will help do more in settings outside the hospital where we can promote health and manage problems at the earliest stage. Our programme of work with primary health care will become more critical, especially ensuring that primary and community-based staff are able to draw on the skill of hospital-based clinicians.
Holding people, systems and structures to account	There will be a clear line of sight from the 'Board to the floor' with every employee understanding how they contribute to the vision and purpose. We especially want our staff and population to be clear about why we are here, and the difference we are trying to make. Our leaders will be supported by strong clinical governance

One health system

The hospital is dominant in the health system and is necessarily focused on treating serious problems. The growth in demand on hospital services is not sustainable into the future. While hospital services will always have a vital role in restoring health and independence, in future years we will see a greater focus on community and primary healthcare and disability services.

Our environment needs to support good health and independence, especially in the settings where people live, learn, work and play. This means being prepared to deliver services differently and in different settings. We need to do more work in the home, locality and community where people are best able to direct their own pathway to health, wellbeing and independence.



One health system – four settings for health, independence and wellbeing

We will continue to work with other sectors to achieve the Better Public Services targets set for health:

- The Prime Minister's Youth Mental Health Project
- The Children's Action Plan
- Whānau Ora
- Reduced rates of Rheumatic Fever.

We will build upon and complement existing integration developments, such as the palliative care model, B4 school check service model and the multi-disciplinary child protection practice. The core components of successful system integration are strong clinical leadership, clinical redesign, care navigation, patient-developed care plans, new models of care and the development of care pathways. These components will be supported by:

- Improving relationships between the DHB, primary care and Te Runanga O Ngati Whatua through our newly formed District Alliance
- Building capability and capacity in primary care
- Driving performance through quality improvement and transparent reporting
- Developing innovative funding models that enable and support sustainable, clinically led service change
- Organisation culture and norms of behaviour that support redesign processes and clinical leadership
- Priority focus on Māori, Pacific and other high need populations.

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

National

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

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

Our 2015/16 Annual Plan reflects the Minister's expectations of ensuring that we remain within budget and financially sustainable now and into the future, develop strong leadership, continue working towards a fully integrated health system, and address the key drivers of morbidity within our district, with a focus on outcomes for children. The Minister's expectations require a focus on the following priorities:

- **Fiscal Discipline/Management of the Health Portfolio** – We need to budget and work within our allocated funding. Improvements to drive cost savings, productivity, purchasing operations and quality via national, regional and sub-regional initiatives must continue to be a key focus for us
- **Leadership** – Strong clinical leadership and engagement is to be embedded and utilised in all aspects of our core business. Our governance, senior management and clinical leaders need to work together to drive service improvements
- **Integration between Primary and Secondary Care** – Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, the ageing population and patients in general. Pathways to achieve better coordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings
- **National Health Targets** – We must remain focused on achieving and improving our performance against the National Health Targets, particularly the primary care targets. We need to work directly with primary health organisations and individual practices to drive this performance
- **Tackling Key Drivers of Morbidity** – The DHB needs to address the major drivers of morbidity within our district and ensure that our residents are healthy. A key focus in this area is on the health of children.

Regional

In delivering its commitment to 'better, sooner, more convenient health services', the government has clear expectations of increased regional collaboration and alignment between DHBs. While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address the shared challenges and support improved patient care and more efficient use of resources.

The Northern Region DHBs have a strong history of working together. The Northern Region Health Plan was developed by the four Northern Region DHBs and primary care Alliance Partners. The agreed direction for our region is set out in the Northern Region Charter[2].

To achieve these gains, the Northern Region has three key goal areas that the regional DHBs are expected to deliver across all areas and where they need to demonstrate achievement of the Northern Regional Health Plan Mission and triple aim objectives. The Northern Region Health Plan sets out three key priority goals, which are:

Goal One – First, Do No Harm: Patient safety is a priority for the Northern Region. By adopting a regional approach, we aim to achieve a focused effort on improving the quality and safety of the health system.

Goal Two – Life and Years: The objective of this goal is to reduce disparities and achieve longer, healthier and more productive lives for our population. Many of the work areas covered by this goal represent our region's greatest opportunities for gain. Priority work areas include Child Health, Inequities and Inequalities (with an emphasis on health gain in Māori[3]), Health of Older People, Cancer Services, Cardiovascular Disease, Diabetes, Major Trauma, Mental Health and Addiction Services, Stroke, and Youth Health.

Goal Three – The Informed Patient: The objective of this goal is to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum, from prevention and early diagnosis to better disease treatment. One of the key action areas in achieving this goal involves Advance Care Planning. The primary aim of this goal is to ensure that patients are better informed about future care and treatment choices and that healthcare providers are better informed about patient's care preferences, particularly around end-of-life care.

Sub-regional

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

[2] The Northern Regional Health plan containing the Northern Region Charter can be found at: http://www.NDSA.co.nz/FormsDocuments.aspx

[3] The Māori Health Plan, a companion document to the Annual Plan, sets out key performance measures for health services. Māori health and reducing inequities are addressed throughout the Annual Plan.

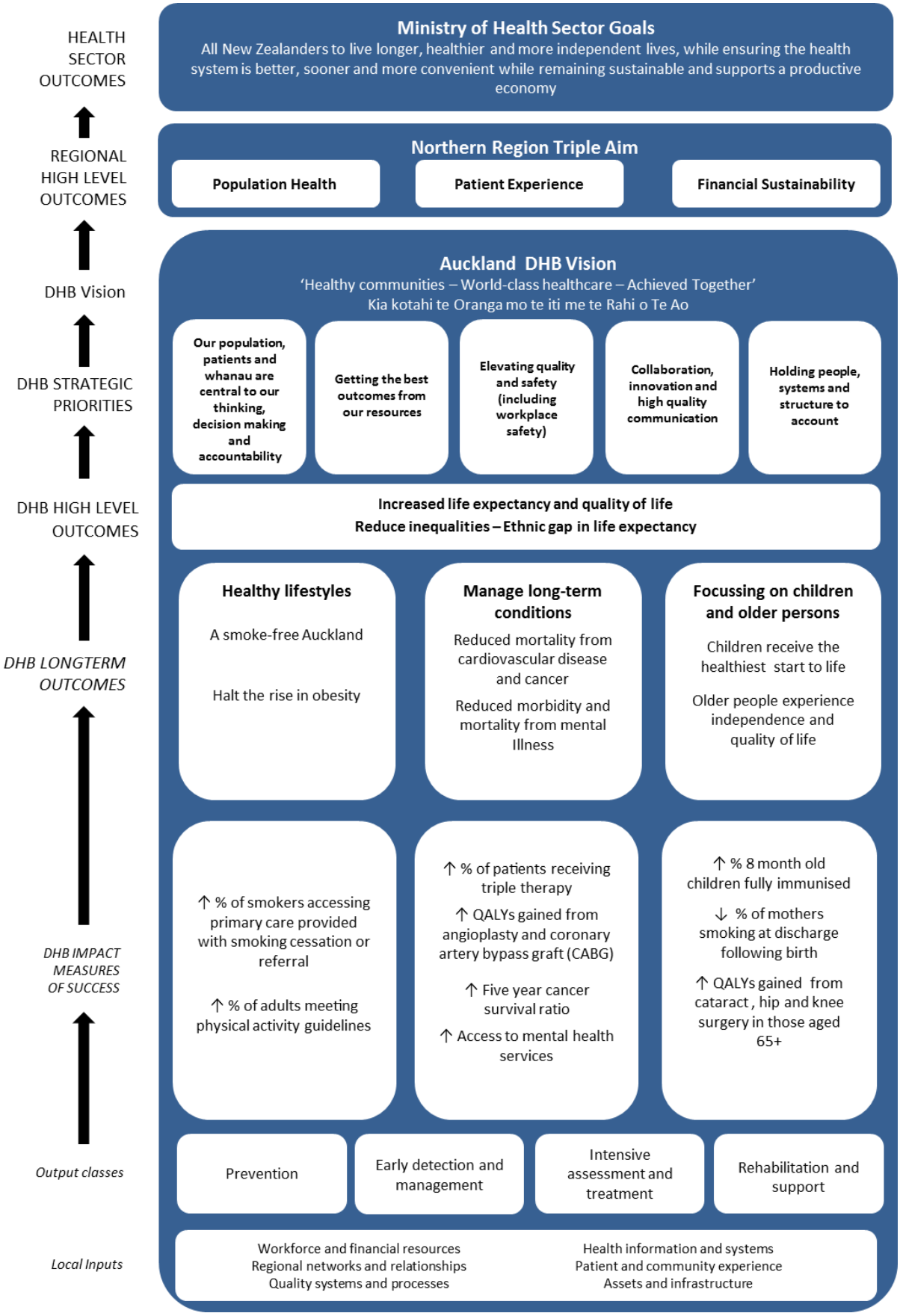
Intervention logic and outcomes framework

The intervention logic and outcomes framework for Auckland DHB summarises the key national, regional and local priorities that inform this 2015/16 Annual Plan, including the key measures we monitor to ensure that we are achieving our objectives. Our outcomes framework enables the DHB to ensure it is achieving its vision and delivering the best possible outcomes across the whole system for our population. Our framework is based on the 'Triple Aim' – population health, patient experience and cost/productivity. These are based on our role and function as a DHB and aligned with the Northern Region Health Plan and World Health Organisation guidance for health system performance measurement and improvement.

We have identified two overall outcomes and several outcome measures and high level impact measures that will demonstrate whether we are delivering our vision and improving the health and wellbeing of our population. These outcomes and measures are presented in the intervention logic diagram on the following page.

We will refine this framework and develop metrics and a reporting process by working with our clinical leaders, primary care and MOU partners. The measures included in our outcomes framework will be updated through this process. We intend to align this to the Integrated Performance Improvement Framework (IPIF) as it is developed. The Strategy work in progress will also lead to changes in outcomes measures. The Statement of Performance Expectations in Module 3 sets out a more detailed set of indicators that contribute to our overall outcomes framework.

Intervention logic and outcomes framework



Overall outcomes

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

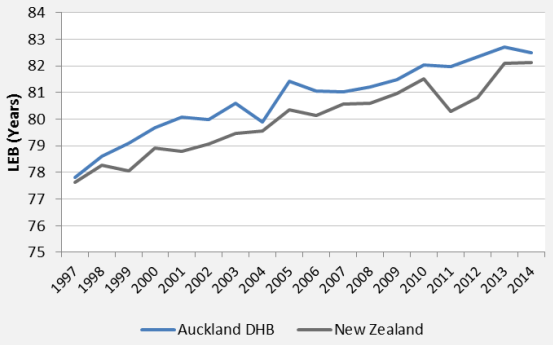
Key

✔ Indicates an outcome measure has achieved its target, trending in the desired direction, or is performing better than the national average. (The absence of a tick does not necessarily indicate poor performance, as not all measures have targets or are compared with national rates.)

Overall outcome – Increase life expectancy and quality of life

Life expectancy at birth (LEB) is recognised as a general measure of population health status. In Auckland, life expectancy has increased by 2.6 years over the last decade, a similar increase to that seen in New Zealand. Overall, we continue to have one of the highest life expectancies in the country at around 82.5 years, slightly higher to that observed nationally.

Outcome Measure – An Increase in Life expectancy at birth ✔

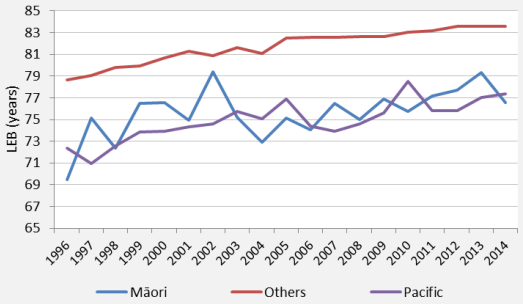


Overall outcome – Reduce inequalities for all populations

There are significant differences in life expectancy between ethnic groups within our district. Māori and Pacific people have a lower life expectancy and live on average 6 years less when compared with other ethnicities. Circulatory disease, cancer and diabetes accounted for over half of the difference in life expectancy between Māori or Pacific people versus European/Other ethnicities in Auckland.

Although life expectancy is increasing in our Maori and Pacific population, the rate of increase is not as large as that seen in our other population groups. Our target over the coming years is to reduce this gap in life expectancy for our Māori and Pacific population.

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



Healthy lifestyles

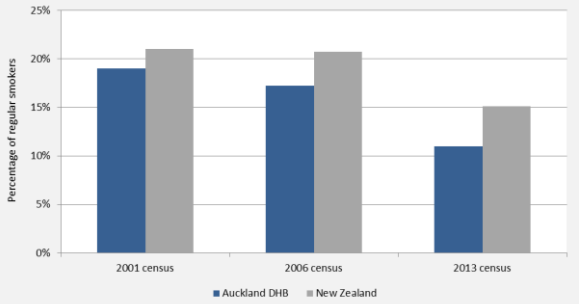
To improve health and equity for our population, we want to see Aucklanders take more responsibility for their own health, at home, in their neighbourhoods and the everyday places where real health belongs. Everyday lifestyle choices make a difference to individual health and to reducing the burden associated with cancer, cardiovascular disease and diabetes. Our focus in this area is on smoking and obesity. In these areas, we will ensure that people are better protected from harm, informed of the signs and symptoms of ill health, and supported to lead healthy lives. We will create health-promoting physical and social environments, which support people to take more responsibility for their own health and make healthier choices.

Outcome – A smokefree Auckland by 2025

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

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

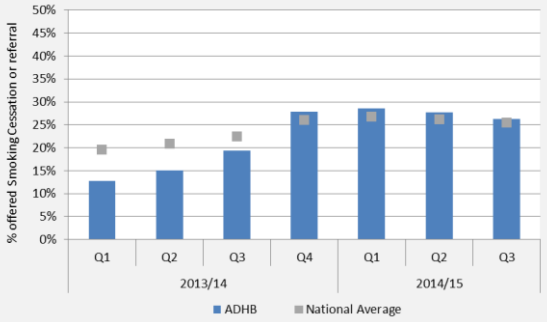
Outcome measure – A reduction in smoking prevalence



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

We have seen a steady increase in the proportion of smokers accessing primary care that are provided with smoking cessation support either through a referral to 'quit smoking' services or provided with pharmacological smoking cessation aids. Our aim is to continue this trend and ensure we are supporting smokers in their quit attempt.

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

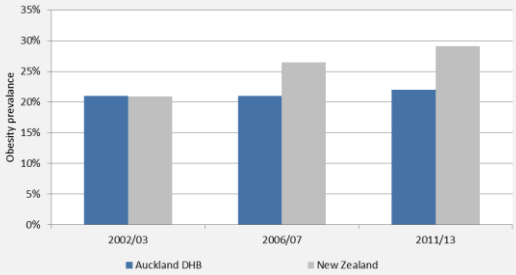


Outcome – Halt the rise in obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Not only does obesity impact on quality of life, but it is a significant risk factor for many chronic diseases, including some cancers and cardiovascular disease. The associated costs of obesity are estimated to be 4.4% of healthcare expenditure (or $152 million) for the overall Auckland region and are rising.

The prevalence of obesity is lower in Auckland compared with New Zealand, but it is increasing. Nearly one in five of our population aged 15+ years are considered to be obese.

Outcome Measure – A reduction in the prevalence of Adult (aged 15+) Obesity

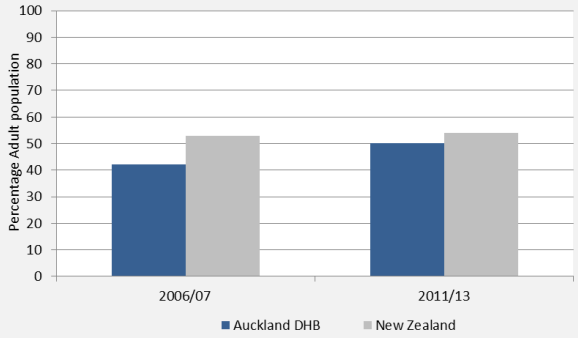


Outcome – Halt the rise in obesity

Keeping active can help people stay at a healthy weight or lose weight. It can also lower the risk of heart disease, diabetes, stroke, high blood pressure, osteoporosis, and certain cancers. Inactive (sedentary) lifestyles do just the opposite. Even small increases in physical activity can produce measurable health benefits.

Despite all the health benefits of physical activity, our adult population are exercising less. Current New Zealand guidelines recommend 30 minutes of moderate-intensity physical activity (or equivalent) on at least five out of seven days. Increasing the proportion of our adult population exercising will assist in halting the rise in adult obesity and will have a positive impact on other health outcomes.

Impact Measure – An increase in the percentage of our adult population meeting physical activity guidelines



Managing long-term conditions

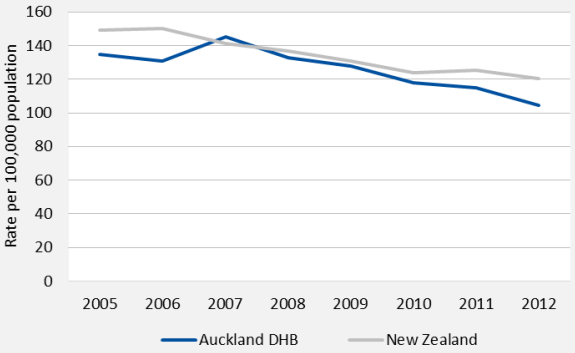
We aim to improve the detection and management of long-term conditions such as cancer and CVD as well people suffering poor mental health. We have made significant progress in improving the management of long-term conditions. This is reflected in the reduction in the rates of mortality from CVD and cancer. However, more can be done to increase the number of years of healthy life lived and reduce disability for our patients, particularly for our Māori and Pacific population.

Outcome – Reduced mortality from cardiovascular disease (CVD)

CVD is a leading cause of mortality in Auckland and it contributes significantly to premature deaths. CVD is largely preventable with lifestyle change, early intervention and effective management. Significant gains have been made over the past decade in the treatment of CVD and improvements in lifestyle, but to ensure a continuous reduction in the rate of mortality from CVD, there needs to be concerted action in both prevention and treatment.

Mortality due to CVD has declined steadily over the years and continues to trend downwards. The rate in Auckland is consistently lower than the national rate, and remains one of the lowest in the country.

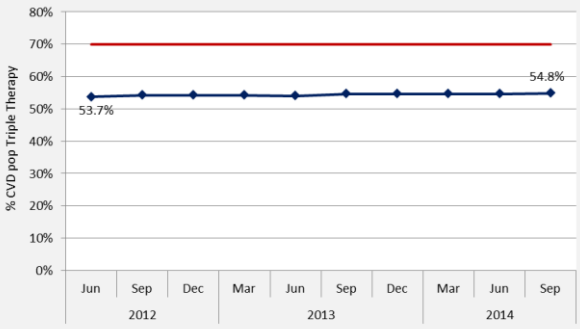
Outcome Measure – A reduction in the rate of mortality due to cardiovascular disease ✔



Current New Zealand guidelines recommend that people who experience a heart attack or stroke, and where not contraindicated, should be treated with a combination of medication known as triple therapy (defined as taking aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin). Although there is no clear clinical evidence to set prescribing targets for triple therapy, the National Cardiac Network has agreed that our aspirational target for triple therapy should be 70%. This indicator does not include patients that started therapy within a year of the most recent reporting month.

We can make significant progress in ensuring that our patients who have had a CVD event are receiving the best possible care and adhering to their triple therapy medication. Currently, slightly less than 55% of our population that have had a CVD event are on and adhering to their triple therapy medication.

Impact Measure – 70% of identified CVD population aged 30+ years are receiving and adhering to triple therapy

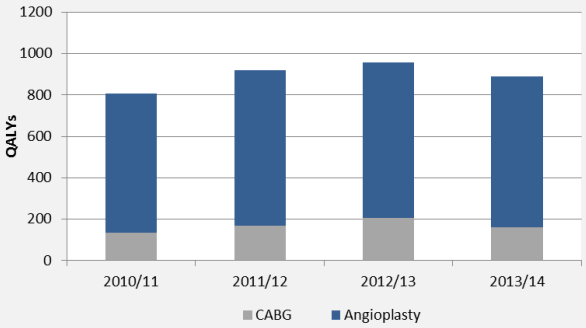


Outcome – Reduced mortality from cardiovascular disease (CVD)

A widely used measure of the impact of medical/surgical interventions is the Quality Adjusted Life Year (QALY). QALYs measure the length and quality of extra years gained by a medical/surgical intervention. QALYs gained from coronary artery by-pass grafting and angioplasty have been estimated. Using these values, we can estimate how many years of quality life are gained by our population through the aforementioned procedures and interventions.

In 2013/14, we added over 880 QALYs to those having the aforementioned procedures, a 10% increase from 2010/11.

Impact Measure – An increase in the Quality Adjusted Life Years gained from coronary artery by-pass grafting (CABG) and angioplasty procedures

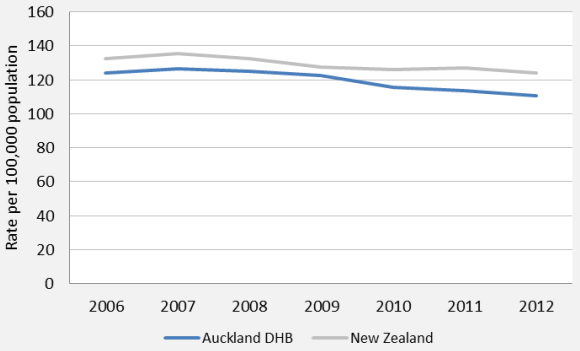


Outcome – Reduced mortality from cancer

Cancer is the second leading causes of mortality in Auckland DHB and contributes significantly to premature deaths. Mortality due to cancer has declined steadily over the years and continues to trend downwards. The rate in Auckland is consistently lower than the national rate, and remains one of the lowest in the country.

To ensure that there continues to be a reduction in mortality from cancer, there needs to be concerted action in both prevention and treatment

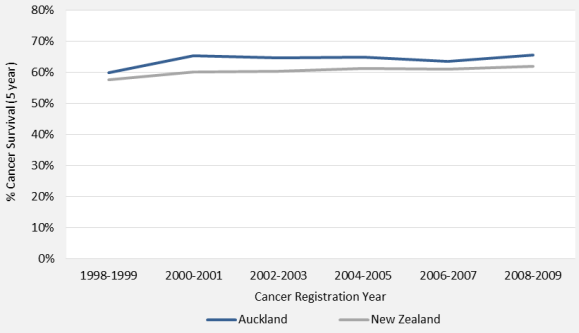
Outcome Measure - A reduction in the cancer mortality rate



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

We have seen a steady rise in the five-year survival ratio for people diagnosed with cancer in our district. For all individuals diagnosed with new cancer in 2008-09, the five-year survival rate was 65.6%, meaning that among those diagnosed with cancer, the cancer had reduced the likelihood of surviving five years after diagnosis by 35%. It is important to note the five-year survival ratio varies greatly by cancer type, ranging from 93.7% for prostate cancer, to 13.1% for lung cancer.

Impact measure – An Increase in Five year cancer survival ratio



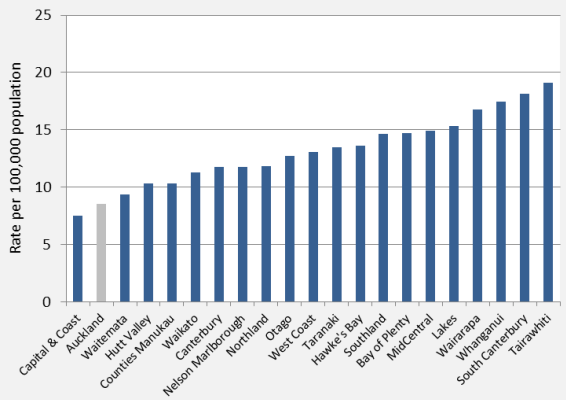
Outcome – Reduced morbidity and mortality from mental illness

Good mental health is an important part of living a complete and fulfilling life. Mental illness is one of the leading causes of disability and overall health loss in our population. Nationally, one in five individuals has a mental illness in any given year, and 3% have a serious mental illness.

Timely access to mental health services in primary care or hospitals and effective treatment can reduce the time spent with a mental illness and reduce the associated morbidity and mortality.

Our five-year suicide rate (2007–2011) is the second lowest in the country and remains below the national rate. However, approximately 40 people die because of suicide each year in the Auckland DHB region a disproportionate number of these individuals are young and Māori.

Outcome Measure – A reduction in suicide rates

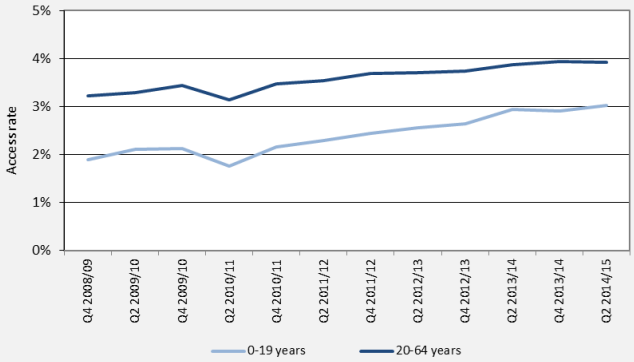


People with a serious mental illness require quality and timely clinical care. Evidence suggests that mental illnesses are less severe, of shorter duration and less likely to recur when identified and treated early.

Low treatment rates for people with a mental illness and/or addiction may be due to several factors. These may include unavailability of services, a lack of awareness, previous negative experiences and the stigma associated with mental illness.

Timely access to mental health services in primary care or hospitals and effective treatment can reduce the time spent with a mental illness and reduce the associated morbidity and mortality. The percentage of our population who access secondary mental health services has steadily increased. Approximately 3.0% of our 0 to 19 year-olds and 3.8% of our 20 to 64 year-olds have accessed mental health services.

Impact Measure – Percentage of people <19 and 20-64 years with access to mental health services.



Focusing on children and older persons

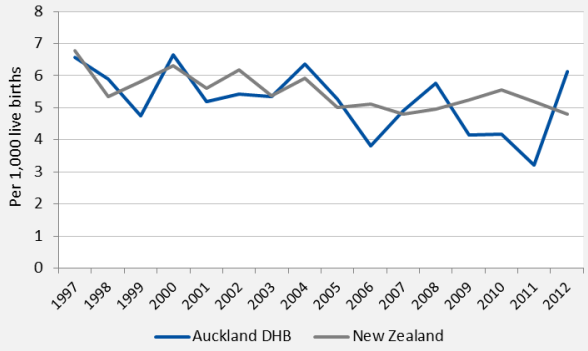
Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Many risk and protective factors and social patterns established in childhood and adolescence have a significant long-term impact on health. Healthy children are more likely to become healthy adults, therefore positive health outcomes for children and mothers are essential to ensuring that our population is healthy into the future. As our population ages, health services will play a crucial role in supporting our older population to ensure they experience independence and a high quality of life.

Outcome – Children receive the healthiest start in life

Infant mortality is an indicator of the health of both children and the general population. It reflects the relationship between causes of infant mortality and upstream determinants of population health, such as economic, social and environmental conditions.

Auckland DHB's infant mortality rate has trended lower over the past decide. In 2011, the rate was 3.2 per 1000 live births.

Outcome Measure – A reduction in Infant Mortality



Outcome – Children receive the healthiest start in life

Immunisation is not only an effective intervention to protect children from communicable diseases, it also protects entire populations and can be used to help reduce inequalities in the delivery of primary health care.

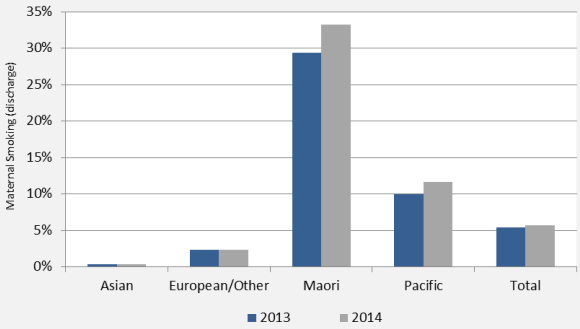
Auckland DHB now has one of the highest immunisation coverage rates in New Zealand. We are now immunising 95% of Auckland children by 8 months of age. This needs to be continued and sustained over the coming years.

Impact Measure – 95% of 8-month-old children who are fully immunised

Maternal smoking is the main modifiable risk factor affecting foetal and infant health. Smoking during pregnancy is associated with serious complications, including stillbirth, premature delivery and low birth weight. Mothers that continue to smoke following birth may have trouble breastfeeding and place their baby at an increased risk of sudden infant death syndrome.

Significant disparities exist in the proportion of mothers who smoke at the time of discharge following birth. Māori mothers are three to six times more likely to smoke than mothers of other ethnicities.

Impact measure – A reduction in maternal smoking measured by smoking status at discharge following birth



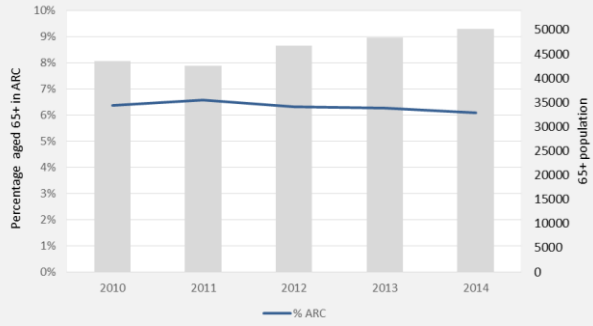
Outcome – Older people experience independence and quality of life

For a number of older people, the care they require can only be provided within an aged residential care (ARC) environment. However, those who are able to live in their own homes and remain connected with their local community generally have better long-term health outcomes.

A decrease in the proportion of the 65+ population living in ARC is a potential proxy indicator for the health of the older population and how well the health system is managing age-related long-term conditions.

We have seen a steady decline in the percentage of our 65+ years living in ARC. This suggests that our older population are gradually becoming healthier and are able to live more independently.

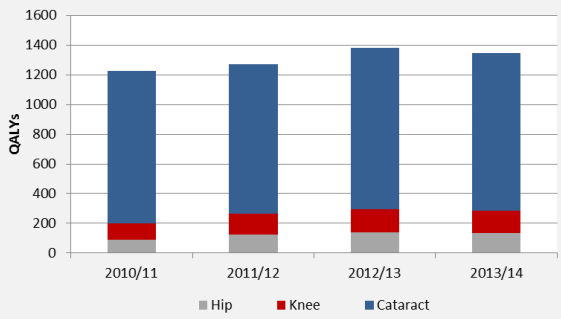
Outcome Measure – A decrease in the proportion of our older population living in aged residential care ✔



Cataract surgery as well as knee and hip replacements can significantly improve the independence and overall quality of life of our older population. Using previously estimated QALY values, we can estimate how many years of quality life are gained by our 65+ population through the aforementioned procedures.

In 2013/14 our 65+ population gained over 1340 QALYs from cataract surgery and hip and knee replacements. This represented a 10% increase from 2010/11. The largest number of QALYs were gained through cataract surgery, followed by knee replacements and hip replacements.

Impact Measure – An increase in the QALYs gained from cataract, knee and hip procedures in our 65+ population



MODULE 2: Targets and Priorities

1) Our population, patients and whānau are central to our thinking, decision making and accountability

A patient- and whānau-centred health system

Every one of us has different expectations and aspirations for our own health and wellbeing. Patients thrive when they are in control of their lives, are able to control their care and have services tailored to their needs. Our values (Welcome -Haere Mai, Respect - Manaaki, Together- Tuhono, and Aim high- Angamua) compel us to work mindfully with patients and communities. This means we make time to stop, listen and hear what matters to each person. We need a system that supports this.

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

In 2015/16, our focus is to develop our patient- and whānau-centred care programme and further develop our patient experience measurement tools. We will continue to identify and utilise opportunities to engage patients, whānau and the community to improve our understanding of patient experience and engagement, cultural safety and cultural responsiveness.

Patient Experience	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Formalise a patient- and whānau-centred care programme by December 2015 • Further develop our patient experience measurement tools by June 2016 • Improve uptake of the National Patient Experience Survey through utilisation of both SMS and email invitations • Improve coverage of our internal patient experience surveys through improved collection of email addresses • Roll out our patient experience survey to cover Emergency Department patients (Dec 2015) and all outpatient areas (June 2016) • Collaborate with the HQSC Consumer Experience programme - ongoing • Roll out initial improvements identified as part of our Public spaces work by December 2015	• Report National Patient Experience Survey quarterly • Achieve and/or maintain the national average ratings in the National Patient Experience Survey for communication (8.3/10), partnership (8.1/10), coordination (8.5/10), and physical and emotional needs (8.0/10) • Continue to improve our internal inpatient and outpatient experience ratings and maintain them above our 2014/15 benchmark (to be set) • Email address collection improves 25% on baseline (to be set) by June 2016

Community Participation	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• In partnership with relevant stakeholders, we will design and test prototype innovations in primary care aimed at advancing mental health and wellbeing. Using a rapid co-design process, the community will contribute to service redesign and integration solutions from April 2015 • Continue working with the Maungakiekie Local Health Partnership group to develop and deliver a local health and wellbeing directory of services and community-led navigation resources • Re-design and implement coordination functions for the new Reo Ora Health Voice platform by July 2015, devise communication strategy and active recruitment plan by August 2015 • Identify services to review health literacy in ADHB using the newly developed Workbase Guide by August 2015, and complete the review by June 2016 • Three services are reviewed with recommendations for improved health literacy by June 2016.	• Agency and community participants will rate ADHB as a highly trusted partner, defined as 80% of stakeholders rating ADHB at four or more points on a 5-point Likert scale. The evaluation framework will be co-designed and will evolve with the prototype innovations. Data relating to how ADHB is perceived as a partner will be gathered and analysed over the course of 2015/16 • Recruit 1000 to 1500 new panel participants for Reo Ora Health Voice in the 2015/16 year.

Promote healthy lifestyles

Common lifestyle choices, such as smoking, lack of physical activity and poor nutrition, are major contributing factors of long-term chronic diseases, including cardiovascular disease and cancer. Addressing these factors will help to mitigate the increasing incidence and impact of chronic disease in our population, both now and in the future.

Smoking - Smoking is the largest single cause of preventable ill health and premature death. The smoking rate has declined substantially in our adult population from 16.5% in 2006 to 11% in 2013. Our district has the lowest smoking rate in the country, and this decline will have positive health implications for our population for many years to come. Despite the decline in smoking rates, significant ethnic disparities still exist within our district. Our 'Ask, Brief advice, and Support to Quit' programme provides quit advice to over 95% of smokers who access primary care and hospital services. In 2015/16, we aim to maintain and improve the current levels of advice and support offered through our Ask, Brief advice, and Support to Quit programme and strengthen the mechanisms to provide on-going cessation support.

Obesity - Low levels of physical activity and poor nutrition affect the health of our population. One in five of our adults are obese and over half are overweight. Although our obesity rates are lower than those observed nationally, there is still room for improvement. In 2015/16, we will support our population to adopt healthy lifestyles through the Healthy Babies Health Futures initiative, improve access to Green Prescriptions and provide timely and efficient access to bariatric surgery. We will also continue to participate in and support Healthy Auckland Together, the regional obesity prevention initiative.

Better Help for Smokers to Quit

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Supporting achievement of the hospital target: • The Smokefree Services Team will ensure that the 'Ask, Brief advice, and Support to Quit' approach will become self-sustaining by providing training, resources and support to the Smokefree Lead in each inpatient hospital service, so they can in turn support their clinical staff to maintain the Health Target - ongoing • Develop a process to follow-up on patients prescribed NRT in hospital by June 2016 • Refresh the training provided to health professionals (to improve the quality of support to quit and increase the number of support quit attempts, particularly to Māori and Pacific patients) - by December 2015 • Ensure that ABC training is available to all health professionals, including community and child health, mental health and addictions, Māori and Pacific teams - by June 16.	• 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking by June 2016 • Increase the number of referrals from hospital services to stop smoking services by 100 per month by quarter 4 of 2015/16
Supporting achievement of the primary care target: • The DHB will contract with each PHO to lead and coordinate support to General Practices including: setting key performance indicators, regular feedback on performance, IT tools and clinical champions - ongoing • Implement a project to address with low referral rates to stop smoking services - by December 2015 • Refresh the training provided to General Practices (to improve the quality of support to quit and increase the number of support quit attempts, particularly to Māori and Pacific patients) - by June 2016.	• 90% of patients who smoke and are seen by a health professional in primary care are offered brief advice and support to quit smoking by June 2016
Supporting achievement of the maternity target: Ensure that pregnant women have easy access to appropriate antenatal and postnatal stop smoking services by: • Implementing an incentives scheme – by October 2015 • Develop and implement a communications plan that promotes quitting to pregnant women and their whānau – by December 2015 • Build on the training provided by Innovat8 to ensure that all midwives and General Practice staff can support pregnant women to quit - ongoing • Build relationships between Lead Maternity Carers, Maternity Services, Well Child Tamariki Ora providers and all locally available stop smoking services – ongoing.	• 90% of pregnant women who smoke at the time of confirmation of pregnancy are offered brief advice and support to quit
Supporting quit smoking services across the district: • Support the DHB and regional Mental Health and Addictions NGO smokefree project – ongoing • Facilitate the ABC programme training to other health professionals in the NGO sector (e.g. dentists, sonographers) – by June 2016.	

Obesity

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

• We will develop a local childhood obesity plan once national advice has been provided, in consultation with the northern region DHBs and Auckland Regional Public Health Service
• Continue to support the implementation of the Healthy Babies Healthy Futures project:
  ○ Provide women with key breastfeeding messages through text messaging, community promotion, and support groups – ongoing
  ○ Continue to work with our Auckland and Waitemata Collective partners to target specific ethnic groups (Māori, Pacific, Asian, Chinese, Korean and Japanese) – ongoing
  ○ All stages of the Text Match messages (multi-lingual) to be developed by April 2015
  ○ Double last year's number of family support members registered (target of 344) by December 2015
  ○ Double last year's number of staff trained in Healthy Conversational Skills (target of 50) by December 2015
  ○ Evaluate the project by June 2016
• Work with the bariatric service, including surgeons, to identify and remedy barriers within the triage service which hinder acceptance of Māori and Pacific people onto the bariatric surgery waiting list – by September 2015
• Collate bariatric surgery figures for 2014/15 by ethnicity to assess procedure rates for Māori and Pacific patients to establish a baseline for 2015/16 – by July 2015
• Implement Healthy Eating Guidelines within Healthy Village Action Zone (HVAZ) church/community groups (guidelines require 15 policies to be implemented to achieve gold accreditation, 7 for silver and 3 for bronze) – by June 2016
• Support and participate in the Healthy Auckland Together inter-sectorial group to progress regional actions to improve physical activity and nutrition – ongoing
• Conduct monthly monitoring of all retail outlets on Auckland DHB premises to ensure outlet compliance with the DHB's food and beverage guideline
• Conduct the Aiga Challenge Programme (an 8-week, church-based, weight loss programme) in October 2015.
	• 6,900 people to receive a green prescription referral by June 2016
	• 800 people to register and complete the Aiga Challenge programme by June 2016
	• 10 new HVAZ groups to achieve bronze accreditation, 32 to achieve at least silver accreditation by June 2016
	• Compliance with DHB food and beverage guidelines for all Auckland DHB based retail outlets by June 2016

More attention on the young and old

Ensuring positive health outcomes for children, young people and mothers is essential to maintaining a healthy population. Risk and protective factors and social patterns established in childhood and adolescence have a significant long-term impact on health. As our population ages, more support is needed to stay healthy.

We will work collaboratively with primary care and other social sector agencies to ensure that parents receive the best maternity care, and children and young people are safe and have the healthiest start to life, no matter where they live or what their background is. Many common mental health problems, such as depression, anxiety and substance abuse, emerge when people are young and have life-long consequences. As well as ensuring the health of our children and young people, we also need to keep our growing number of older people healthy and independent.

Maternal and Child Health – We have made substantial progress in recent years to ensure that pregnant women engage with health services early and children have the healthiest start to life. Our infant mortality rate is lower than that observed nationally. Over 64% of Auckland women are registered with an LMC by 12 weeks of pregnancy; we are aiming to achieve 80%. Uptake of breastfeeding at discharge from hospital is currently 79%. PHO and General Practice enrolment rates for three-month-olds have improved to 72%, an increase of 51% from 2012. We have reached 95% immunisation coverage for 8-month-olds and 96% for 2-year-olds. Seventy nine percent of infants received all core contacts with their Well Child/Tamariki Ora provider and 92% of four-year-olds received a comprehensive health check before starting school; however, inequalities exist for our Māori and Pacific infants.

For 2015/16, we have a number of key focus areas in maternal and children's health. We will work with primary care and general practices to promote and support early LMC engagement through a regional pathway for first semester care and support the LMC model of care with direct access to obstetric clinicians. In the area of child health, we will focus on strong governance and integrating services across the child health spectrum. We aim to strengthen the First Year of Life Service Alliance and ensure it improves child health outcomes. We will have a strong focus on the Multi Enrolment Project, whereby new-borns are referred to enrol into all appropriate services through a single entry point. The Rheumatic Fever Programme Plan will be reviewed. We will continue to support the Rheumatic Fever Rapid Response clinics established in a number of general practices and pharmacies and enhance our school based screening services in primary and high needs secondary schools. To protect vulnerable children in our district, we will support the prevention and early identification of child maltreatment and neglect by delivering on the New Zealand Children's Action Plan and aligned initiatives. We will support the implementation of regional Children's Teams and enhance interagency capacity and the continuum of care through regional information sharing and strengthening linkages with partner organisations.

Youth Mental Health - Early intervention to appropriate services for those with mental health problems and substance abuse issues will have a positive impact on health outcomes in young people. In 2015/16, our focus is to continue to enhance school-based health services and further develop youth primary mental health and alcohol and drug services. This will ensure these services are accessible and responsive to youths and that services are intervening early. We will work collaboratively with other social services to ensure that at-risk young people have access to services. We also aim to better understand and address inequalities in mental health service access and outcomes, and to develop and implement culturally appropriate service models.

Health of Older People - By 2025 there will be nearly 75,000 people aged 65+ living in our district, making up nearly 14% of the total population. Older people are large consumers of health care resources, currently occupying about 45% of our medical and surgical beds. Our aim is to ensure older people receive coordinated and responsive health and disability services that are accessible, flexible and timely.

Integrating primary and community care across the health system enables patients to be treated closer to home, and with fewer acute and unplanned admissions into hospital.

In 2015/16, we will focus on further integrating primary and community care so that older people can receive the care they need in the most appropriate place. The continued implementation of a standardised clinical assessment across the home and community sector will support this aim. A further focus is on improving outcomes for patients with dementia through the development of a business case for the implementation of the Dementia care pathway.

Child Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Ensure that the Pregnancy and First Year of Life Service Alliance provides effective governance and begins to address transition issues between provider groups – ongoing. **Enrolment** • Implement the Multi Enrolment Project to refer newborns for enrolment into a range of services (NIR, General Practice, Oral Health, Well Child/Tamariki Ora providers and Newborn Hearing screening) and to increase equity of access to services by April 2016. **Well Child/Tamariki Ora (WCTO)** • Increase antenatal referrals to WCTO by requiring the community midwife service to refer all first-time mothers and women under the care of CYF to a WCTO provider from July 2015 • Make the WCTO Quality Improvement Framework a living plan by adding at least one new PDSA activity (with a particular emphasis on equity) every quarter from September 2015. **Breastfeeding** • Work with consumers to analyse the reasons for declining breastfeeding rates for infants aged between 6 weeks and three months (particularly for Māori and Pacific infants), and present recommended actions to the Alliance for consideration by October 2015 • Implement the new pregnancy and parenting education smartphone app to encourage all women, particularly Māori, Pacific and Asian, to breastfeed for at least the first 6 months of their baby's life by March 2014 • Implement combined Well Child Tamariki Ora and Midwifery breastfeeding education training for professionals from March 2016 • Implement the Breastfeeding – Beginners Guide (Chinese/Mandarin) across all maternity units in the Auckland DHB region by December 2015. **Oral Health** • Collaborate with oral health clinical leaders and service	• Achieve equity across all target areas for Māori, Pacific and Asian groups by June 2016 • 98% of newborns are enrolled with a PHO, general practice, WCTO provider and ARDS by three months for all ethnicities by June 2016 • 95% of Māori pre-school children are enrolled with ARDS by June 2016 • Provide a minimum of two oral health provider education workshops for WCTO and whānau ora workers and community health workers by June 2016 • At least four PDSA activities to improve the quality of the WCTO programme are underway by June 2016 • At least 90% of four-year-olds receive a B4 school check, including 90% of Māori and Pacific Children and children living in areas of high deprivation

Child Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
management to identify areas for further regional collaboration in approaches to oral health data collection, reporting and activities by December 2015 • Work with ARDS to develop and implement at least one action to increase oral health care service utilisation by infants aged less than 1 year, with a particular focus on Māori infants, by June 2016 • Review enrolment pathways for newborns and for children aged under five years who are new to New Zealand by December 2015. **B4SC** • Maintain the positive progress towards achieving equity of access for Māori and Pacific children to the B4SC programme by continuing to target delivery in settings such as Kōhanga Reo and Pacific language nests - ongoing • Investigate opportunities to extend the pilot into Puna Reo and other early childhood centres with high Māori enrolment rates from May 2016. **Spinal Cord Impairment Action Plan** • Lead a process to disseminate spinal cord impairment information nationally, particularly to ED, Orthopaedic and Paediatric services from July 2015 • Finalise the Acute Child Guideline by December 2015 • Work with ACC to develop a more comprehensive rehabilitation process, including earlier inpatient rehabilitation and outreach services with draft process agreed by June 2016 • Engage with ambulance providers to implement the spinal cord information pre-hospital destination and referral pathway – ongoing.	

Maternal Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Develop and consult on a maternity plan to 2025 and report (with service-enhancement recommendations) to the Board in October 2015. **Continuity of Care** • Develop a plan to make ADHB a more attractive area to self-employed LMCs through enhancing maternity services that will be communicated during 2016 – by June 2016. **Registration with LMC** • Work with primary care/general practices to promote and support early LMC registration and implement the regional GP pathway for first trimester care in pregnancy by March	• 98% of newborns are enrolled with a PHO by three months • 95% of pregnant women of all ethnicities to receive continuity of primary maternity care through a community or DHB LMC • 80% of women of all ethnicities who register with an LMC do so in the first trimester • 30% of Māori, Pacific and teen pregnant women complete DHB-funded pregnancy and parenting

Maternal Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
2016 • Implement early engagement communications for women and their families from March 2016. **Pregnancy and Parenting** • Rejuvenate pregnancy and parenting education and ensure that women, families and whānau have access to a range of meaningful evidence-based information through an RFP process that supports both traditional and targeted one-off education approaches, supported by increased web-based information by June 2016, such as with a smartphone app to be implemented from March 2016 • Monitor the implementation of the pregnancy and parenting curriculum and assess whether the new model better engages target populations from April 2016. **Gestational Diabetes Mellitus** • Implement new guidelines, as appropriate, by June 2016 • Work with regional counterparts to agree a regional approach for women with a HbA1C of 41% to 49% in the first trimester by June 2016 • Review the dietitian resource and identify gaps in the service by December 2015.	education • 90% of pregnant women of all ethnicities who smoke (i.e. identify as smokers on confirmation of pregnancy in general practice or booking with an LMC) will be offered advice and support to quit smoking • The proportion of women birthing at Auckland DHB and cared for by a self-employed LMC increases from 74.5% to 76.0% by June 2016.

Increased Immunisation

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Monitor immunisation coverage rates weekly with ongoing focus on achieving equity for Māori babies • Liaise closely with the Auckland and Waitemata Immunisation Operations Group, PHOs and the NIR to detect early and action problem solving measures - ongoing • Facilitate development of communication tools and run education workshops for primary care providers regarding immunisation declines and delays –from July 2015 • In conjunction with PHOs and the Department of Corrections, develop health literacy education workshops for parents sentenced to community service by June 2015 • Develop a working group and Project Implementation Plan for the Multi Newborn Enrolment Project by July 2015 • Implement the Shared Approach Plan to increase GP/PHO enrolment, particularly for Māori, by September 2015 • Embed the 2015 Immunisation Coordination delivery model by July 2015 • Maintain the effectiveness and engagement of key stakeholders in the Joint Auckland DHB/Waitemata DHB Immunisation Steering Group and Auckland Metro School-Based Immunisation Working Group – ongoing	• 95% of 8 month old and 2 year old children of all ethnicities are fully immunised by July 2015 and maintained • 90% of four-year-olds are fully immunised by age 5 (reported quarterly) by June 2016 (the long-term target is 95%) • 98% of new-born children of all ethnicities are enrolled with a GP by age three months by June 2016 • Narrative report on DHB and interagency activities to promote immunisation week (completed by early 2016) • 65% of girls have received HPV dose three – reported annually in quarter 4 (for 2015/16, this will be the 2002 birth cohort measured at 30 June 2016)

Increased Immunisation

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Work with the DHB Immunisation Steering Group to develop a plan to increase the 4-year-old immunisation coverage, particularly for Māori, by August 2015 • Maintain current Auckland DHB ED and inpatient services process to report and refer all children identified at presentation who require immunisation – ongoing. Review the feasibility of extending to out-patients services by June 2016 • Develop plan for Immunisation Week 2016, including the Department of Corrections component, by February 2016 • Develop a promotion plan for use of the online learning tool to improve knowledge of HPV immunisations – by March 2016.	

Rheumatic Fever

Better Public Service Target

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Review and revise the Auckland DHB Rheumatic Fever Programme Plan in line with Ministry expectations by October 2015 • Complete an evaluation of the effectiveness of the school-based throat swabbing and management programme including health literacy by September 2015 • Introduce community health workers into 4 high-needs secondary schools to support the rapid response programme by April 2015 • Ensure that all eligible referrals for housing-related concerns are sent to the Auckland Wide Healthy Housing Initiative (AWHI) Hub and that systems and relationships support referrers to help keep families informed – ongoing • Use the Results-Based Accountability framework to monitor and improve the performance of the DHB – AWHI service system for reducing structural and functional overcrowding – ongoing • Train at least 60 non-health front-line staff who interface with the target group from at least three organisations about the importance of sore throats and seeking medical help by December 2015 • Engage the Rheumatic Fever target population at a local level in at least 3 geographical areas regarding the importance of sore throats and seeking medical help by December 2015 • Maintain the intensive school-based throat swabbing and management programme in 16 primary schools - ongoing • Monitor the effectiveness of the Rapid Response Clinics in general practice and in pharmacy monthly, through the	• Reduce rheumatic fever rate to 1.4 per 100,000 or 7 people experiencing a first-episode rheumatic fever hospitalisation by June 2016 • 95% of those eligible have completed referrals made to AWHI over 2015/16

Rheumatic Fever	Better Public Service Target
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Rheumatic Fever Service Alliance Leadership Team – ongoing • Report quarterly to the Ministry on the lessons learned and actions taken following the root cause analysis of cases of first episode rheumatic fever hospitalisations and implement relevant learnings – ongoing • Develop the concept for a mobile app that focuses on self-care and a whānau ora approach to ensure that people who currently have the disease are getting the best possible healthcare by December 2015 • Development of a lead indicator on acute hospitalisations (with quarterly reports) by August 2015 • Development of a feedback loop-education for clinicians re: the result of housing referrals by October 2015.	

Children's Action Plan	Better Public Service Target
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Reducing the number of assaults on children
• Maintain and evaluate the VIP programme and its implementation and continually update the VIP strategic plan based on evaluations, audits and other information - ongoing
• Maintain the National Child Protection Alerts System - ongoing, and align with other child protection information systems including the regional maternity alert system, as and when implemented
• Review family violence screening in primary care settings, including A+Ms – by June 2016
• Review, revise and align child protection policies with NGO and primary care partners by June 2016
• Agree on common Auckland district child protection policy between key stakeholders by December 2015
• Ensure that contracted providers have implemented child protection policies and comply with the Vulnerable Children Act - ongoing
• Monitor screening rates for family violence in child health, women's health, emergency and mental health and alcohol and addiction services and provide regular feedback to encourage improvement - ongoing
• Ensure intervention pathways for family violence are clear and resourced adequately - ongoing
• Commence process to identify mental health and alcohol and drugs patients who are caring for children – by March 2016
• Complete Whānau Ora assessments for Māori children and women admitted to Starship and Auckland City hospitals
	• Family violence (FV) screening coverage rates and referrals by key NGOs, primary care and the DHB will be reviewed by the FV governance group at every meeting
	• Reports of concern to CYF across the Auckland district will be discussed with CYF quarterly
	• Complete exception reports and remedial actions to audit scores less than 80/100 for both the child and partner abuse components of our VIP programme
	• Monitor NCPAS and other child protection information systems by 30 June 2016
	• Maintain internal governance/engagement arrangements with primary and community partners to provide services for:
	  ○ vulnerable children and their families/whānau
	  ○ pregnant women with complex needs
	  ○ children referred to Gateway
	• Support the implementation of Rising to the Challenge (e.g. COPMIA)
	• Support for Healthy Beginnings:

Rheumatic Fever	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
and referred to health social workers who would potentially benefit from such assessments – to commence by October 2015 • Implement national guidance on the management of neglect of medical care – when available • Monitor family violence screening rates in the community, and encourage improvement in rates, particularly through Well Child Tamariki Ora providers -ongoing • Support primary care with more training on child protection from April 2016 • Review the configuration of our key workforces and implement core national competencies from February 2016. **Support implementation of regional Children's Teams** • Build inter-agency capacity through information sharing with the Child Health Stakeholder Advisory Group, with regional DHB counterparts, social sector agencies and key NGOs - ongoing • Foster stronger connections – through the Pregnancy and First Year of Life Service Alliance - between the DHB, primary care, maternity providers and Well Child Tamariki Ora providers – ongoing. **Continuum of services across primary and referred health services** • Strengthen governance and advisory arrangements and linkages between partner organisations by developing a shared vision that will be documented in a shared strategic plan by June 2016.	Developing perinatal and Infant Mental Health Services in NZ.

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Increase access to youth health clinical leadership across Auckland DHB by employing a youth health clinic leader by June 2016 • Increase consumer engagement (youth and whānau) through developing a youth-specific Reo Ora webpage by March 2016 • Develop an accessible training resource (moodle module) for general clinicians who engage with young people – by June 2016 • Undertake a benchmarking audit of youth appropriate care in selected secondary services by June 2016 • Convene a Youth Innovation Forum by March 2016 to explore options including use of IT tools and apps to promote personal resilience, self-management and self-	• 95% of Year 9 students in an ESBHS will have received a HEADSS assessment during 2015 • Waiting time targets for non-urgent mental health and addiction services- 80% seen within 3 weeks, 95% seen within 8 weeks (including child and adolescent mental health services and youth alcohol and drug services) are achieved • Benchmark audit results of youth appropriate care obtained from at least two service areas by December 2015

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

directed care in the child and youth population.
 	
Enhanced School-Based Health Services (ESBHS)
• Introduce an ESBHS in Auckland Girls Grammar from February 2016
• Maintain school-based health services in all other decile one to three schools, teen parent units and alternative education facilities as per specifications - ongoing
• Maintain the visiting school psychologist pilot and conduct an evaluation of the effectiveness of the model of service delivery by December 2015
• Action recommendations following the evaluation of the visiting school psychologist pilot by June 2016
• Implement a system for nurses in alternative education/teen parent units to work under 'standing orders' by December 2015
• Evaluate whether the ESBHS is improving equity by obtaining access breakdowns by ethnicity for Māori and Pacific by February 2016
• Monitor the use of validated mental health screening tools by school nurses and school counsellors to ensure consistent care – ongoing
• Develop an assessment and outcomes framework for HEADSS assessments by June 2016.
 	
Improve the responsiveness of primary care to youth
• Implement phase 2 of the Auckland DHB Youth SLAT work programme:
  ○ Revise the Alliance agreement to align with the district Alliance and review membership by September 2015
  ○ Develop a youth friendly GP accreditation tool by June 2016
  ○ Agree on how to standardise sexual health services, particularly in relation to access, across primary care by December 2015
• Chlamydia rates across ADHB and WDHB are monitored and reported to the SLAT from July 2015.
 	
Child and Adolescent Mental Health and Youth Alcohol and Drug Services
• Continue to implement elements of the Choice and Partnership Approach (CAPA) to reduce waiting times for non-urgent mental health and addictions services for young people - ongoing
• Work collaboratively with Child, Youth and Family Services (CYFS) and Youth Justice to provide services to 'at risk' young people – ongoing
• Ensure that transition plans are provided for youths aged 12-19 years discharged from CAMPHS and Altered High into
	• Youth Innovation Forum participation:
	  ○ 50+ young people
	  ○ 50+ youth service providers
	• Waiting time targets for non-urgent mental health and addiction services - 80% seen within 3 weeks, 95% seen within 8 weeks (including child and adolescent mental health services and youth alcohol and drug services) are achieved
	• 95% of youths aged 12-19 discharged from the CAMHS and Altered High will have a transition plan in place by December 2015
	• Increase the number of CAMPHS consult liaison contacts per quarter from the baseline (129 contacts per quarter) at the start of the project to 150 contacts per quarter by June 2016
	• Altered High Reporting (across the region) by June 2016:
	  ○ at least 150 additional young people will be seen by Altered High
	  ○ 15 AOD assessment and brief intervention training sessions provided to GPs, practice nurses, school health services; 300 health professionals will be trained; and 200 consultation/liaison contacts will be provided

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
primary care using MoH/Werry Centre guidelines – ongoing. Transition plans will specify a timeframe for primary care to follow-up each young person • Deliver the 2015/16 youth-specific actions of the Auckland DHB Suicide Prevention and Postvention Action Plan (2015-17) by June 2016 (please see the Rising to the Challenge section) • Altered High will continue to develop relationships and pathways through training and consult liaison sessions with primary care services (including PHOs, GPs, practice nurses and school-based health services) to improve the provision of alcohol and other drug (AOD) treatment for young people – ongoing.	

Health of Older People	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
Expand resource and support for rapid response and supported discharge in ED though the gerontology presence (e.g. gerontology nurse practitioner) by June 2016 • Plan and begin implementation of the Frailty Pathway by June 2016 • Develop a quality framework for the ARRC population by December 2015 • Establish a support group for Asian owned and operated ARRC facilities by September 2015 • Continue implementation of standardised clinical assessments (interRAI) across the Home and Community sector and ARRC sector – ongoing • Older people referred to NASC for an InterRAI assessment to access publicly funded care services will undergo the assessment in a timely manner – ongoing • Collaborate with Central TAS to develop – through their new integrated InterRAI service –comparative standardised InterRAI quality reporting measures by June 2016 to compare our performance with other northern region DHBs and identify opportunities for quality improvement • Use our Specialist Services for Older People (geriatricians, gerontology nurse specialists, allied health) proactively to advise and train health professionals in ARRC and primary care - ongoing • Develop business cases for provision of improved access to community delivered services including cognitive impairment services (based on the model of care developed with general practice) by December 2015 • Participate in developing regional dementia care components – identified by September 2015 and	• Establish baseline for direct admissions from the community to Auckland City Hospital • Report quarterly on the percentage and number (target 100%) of older people who have received long-term home and community support services in the last 3 months who have had an interRAI Homecare or Contact assessment and completed care plan; 85% having their assessment within a 12-month period • Establish a baseline and report on the proportion of ARRC residents who have a second interRAI LTCF assessment completed 230 days after admission • At least 500 attendances (nurses and health care assistants) from ARRC at Health of Older People Specialist study days • At least 1300 ARRC residents are case managed or provided with a consult by Specialist Services for Health of Older People • At least 60 Auckland hospital staff trained as Dementia Champions by December 2015 • Report quarterly on the proportion of urgent referrals for an interRAI

Health of Older People	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
developed by March 2016 • Implement in-between-travel funding allocation for HBSS Providers as advised by the MoH • Support implementation of agreed components from the negotiated HBSS in-between travel settlement as advised by the MoH • Work with HBSS Steering Group to ensure services are responsive to Maori clients/ whānau – identify elements of a responsive HBSS model for Maori by December 2015 • Maintain and monitor operations of the Fracture Liaison Service - ongoing • Facilitate implementation of the Regional Health of Older People Plan at a district level – ongoing.	assessment completed within 5 days and the proportion of non-urgent referrals completed within 15 days • Ongoing reporting to monitor the Fracture Liaison Service (FLS) is and includes: ○ the total number of patients identified as having a fragility fracture ○ the number of patients assessed by the FLS and the number commenced on therapy (osteoporosis treatment)

Note: regional imperatives will be met from current budget; no additional budget allocations will be made.

We need to tackle inequities in our population

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

Health inequities are preventable and we must minimise unjust differences in health status experienced by certain population groups. While we will directly address these differences inside the health sector, we will also influence other determinants that impact health, such as living and working conditions, socio-economic and environmental conditions, social and community influences, culture, ethnicity and gender.

Māori Health and Pacific Health – Our Māori and Pacific populations live on average 7 years less than other population groups. Circulatory diseases and cancer account for over half of the observed difference. We want all of our people to have good health literacy, with communities active in solving health problems, and strategies in place to overcome barriers, such as access to health services, language and staff cultural competency. We have already made positive gains for our Māori and Pacific people. With a collective approach from across the health system, we are determined to make further progress.

In the coming year we will establish a Whānau Ora network in Tamaki. Services and programmes to improve outcomes for Māori and Pacific children including immunisations, health lifestyles initiatives and PHO enrolment have been prioritised. We will continue to implement the objectives described in the Pacific Health Action Plan.

Asian, New Migrant and Refugee Health – The Asian population accounted for 29% of our district in 2014 and is projected to increase over the coming years. Our Asian and migrant populations are diverse and have specific health needs that are often not generalisable to the entire Asian and migrant population. Our Asian, new migrant and refugee populations require tailored and targeted health interventions and services. We aim to improve access to health services for these population groups and ensure they are culturally and linguistically responsive. This will assist with ensuring improved access and provide early opportunities for intervention, particularly in the areas of CVD and diabetes.

Māori Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Data quality
• Develop e-learning module on ethnicity by December 2015
• Pilot and evaluate the e-learning module by March 2016
• Implement the e-learning tool nationally in a variety of settings in collaboration with the Ministry of Health, DHBs and primary care by June 2016.
 	
Improving access to primary care
• Analyse the proportion of Māori ASH admissions without a GP recorded and develop an approach to increase enrolment in this group by December 2015
• Develop, implement and evaluate a pilot initiative to support prisoners released from prison to enrol with a GP and have a free first visit.
 	
Obesity
• Continue to support the implementation of the Healthy Babies Healthy Futures project:
  ○ Provide women with key breastfeeding messages through text messaging, community promotion and support groups – ongoing
  ○ Continue to work with our Auckland and Waitemata Collective partners to target specific ethnic groups (Maori, Pacific, Chinese, Korean and Japanese) – ongoing
  ○ Evaluate the project by June 2016.
 	
Improving the health of older people
• Work with PHOs to investigate the feasibility of developing and implementing an equity focused incentivised flu vaccination programme for Māori aged 65+ years based in primary care by June 2016
• Offer vaccinator training to registered nurses working in aged and other residential care settings so they can offer vaccinations to eligible people - ongoing
• Develop the capacity of Māori RN workforce by funding Māori nurses within Māori providers to complete the vaccinator's course by March 2016
• Promote vaccinations and record details of Kaumatua and Kuia not vaccinated who are admitted to hospital in collaboration with the He Kamaka Waiora team by June 2016.
 	
Primary Care
• Establish a forum for PHOs to support the maintenance of and improve performance against the Māori Health Plan targets by December 2015.
	Achievement of the following national Māori health targets:
	• 95% of Māori enrolled in PHOs
	• 90% of eligible Māori have their risk assessed within five years
	• 75% of Māori aged ≥65 years received the seasonal influenza vaccine
	• 68% of Māori babies are fully or exclusively breastfed at 6 weeks
	• 54% of Māori babies are fully or exclusively breastfed at 3 months
	• 59% of Māori babies are receiving breast milk at 6 months.

Whānau Ora

Better Public Service Target

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

• Work with Orakei Health Services to support the establishment of a Whānau Ora Network and model of care in the Tamaki locality by June 2016
• Participate in processes led by the Ministry of Health to obtain a broader health sector view on Whānau Ora implementation, including supporting any providers seeking to set up the Whānau Ora Information System - ongoing
• Work with Pasifika Futures to ensure effective integration between whānau ora and Auckland DHB funded family support services as well as identify outcomes for families – ongoing quarterly meetings
• Establishment of a Board-approved whānau ora alliancing group which includes the National Maori Urban Authority by March 2016 to support improved:
  ○ Models of care
  ○ communication
  ○ information sharing
  ○ joint service delivery
  ○ gap identification and problem solving
• Work with Te Pou Matakana and Te Runanga o Ngati Whatua to identify and implement opportunities for co-investment and service co-design – ongoing
• Collaborate with Te Pou Matakana to contribute to the Tamaki Collective impact initiative – ongoing
• Continue to provide a forum for Māori providers to support provider development and input to DHB activities – quarterly.
	• Whānau Ora Network in the Tamaki locality established by June 2016
	• Alliancing group established and approved by the Auckland DHB Board by March 2016
	• Auckland DHB contracts and whānau ora contracts are aligned by June 2016

Pacific Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Implement four Family Violence Prevention programmes, two by December 2015 and a further two by June 2016 • Implement two Parenting Education programmes, one by December 2015 and one further by June 2016 • Update the database of smoke-free churches to ensure that the smoking status of HVAZ by August 2015 churches are recorded • Continue to provide support of the HVAZ programme – ongoing (pending funding) • Provide training for 30 smoking cessation champions from the HVAZ churches/community groups by June 2016 • Conduct the WERO competition and record the number of church and community groups that participated in September 2015 • Conduct the Aiga Challenge in October 2015	• Four Family Violence programmes and two Parenting Education programmes are delivered by June 2016 • 400 staff from ADHB and WDHB will go through the Pacific Best Practice competency training by June 2016

Pacific Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• West Fono will deliver DSME sessions to 180 people by 30 June 2016 • Three parish nurses work with church and community groups to address health needs as identified by health targets and churches/communities, and to develop and implement the Health Action Plans for at least 10 churches and community groups by June 2016 • Monitor and ensure that Pacific cancer patients receive treatment that meets MOH timelines - ongoing • Review contract with AH+ in July/August 2015 in terms of volumes, outcomes and price, and develop new service specifications • Ongoing participation in housing advocacy forums • Support the establishment of two Pacific Health Science Academies for secondary schools in both Auckland and Waitemata DHBs by June 2016 • Set up Pacific nursing and allied health clinical networks for both Auckland and Waitemata DHBs by June 2016.	

Asian, New Migrant and Refugee Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Data Quality
• Establish complete and accurate breakdown data on level 2 Asian subgroups to guide planning and monitoring of services by 30 June 2016
  ○ Identify services with gaps in collecting and reporting of level 1 'Asian' and level 2 categories/subgroups ('Other Asian', 'Chinese', 'Indian', 'South East Asian' and 'Asian NFD')
  ○ Work with identified services to ensure accurate collecting and reporting of level 2 Asian ethnicity subgroups.
 	
Long-Term Conditions
• Ensure access to More Heart and Diabetes Checks for 90% of the eligible population through general practices by 30 June 2016
• Increase communication to South Asian populations on consistent messaging regarding cardiovascular disease and diabetes risk assessments and healthy lifestyle behaviours linking with community organisation partner outreach initiatives by 30 June 2016
• Increase health-promoting messages to Asian communities on preventive and healthy lifestyle behaviours at community organisation workshops and partner self-management programmes by June 2016.
	• 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years, by 30 June 2015, based on accurate ethnicity data collection and reporting protocols
	• 65% of Indian people with diabetes in the Auckland DHB district have an annual review by 30 June 2016
	• 65% of Indian people with diabetes have an HbA1c of <64 mmol/mol by 30 June, 2016
	• 70% of Asian women to complete a breast screen by 30 June 2016
	• 80% of Asian women to have completed a cervical smear by 2020 (the current rate is 59.2% as at September 2014)
	• 95% immunisation rate in infants aged 8 months and 2 years by 30 June, 2016
	• At least 55% of Asian infants are fully breastfed at three months of age by 30 June, 2016

Asian, New Migrant and Refugee Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Child and Maternal Health • Increase messaging and community support to Asian women and their families to encourage continuation of breast feeding from six weeks to three months, linking with the Maternal and Infant Nutrition and Physical Activity Collective and implementation of Service Plans by 30 June, 2016 • Continue to provide input into and support the promotion of Plunket's National Asian Strategy to Asian communities and health services – ongoing. **Women's Health** • Continue to provide free smears for Asian women not screened in the last 5 years or never screened (ongoing) • Identify the current beast screening coverage rate for Asian women, and meet or better the 70% target by June 2016. **Health of Older People** • Monitor the registration of the CALD module 1 and Health of Older People module for Home-Based Support Services and Age-Related Residential Care workforce to upskill the workforce on delivery of culturally competent and responsive care to older adults. **Mental Health** • Maungakiekie/Tamaki locality – Mental Health model of care with Asian, MELAA, new migrant and refugee inputs scoped and developed by June 2016. **Refugee Health** • Provide workforce development training to health professionals on refugee health across the Auckland region by June 2016.	• Three refugee forums delivered annually across Auckland DHB and Waitemata DHB, with Counties Manukau DHB engagement by 30 June, 2016

2) Getting the best outcomes from our resources

Focus on the major causes of ill health

We have a significant role to play in improving the management of ill health, in particular in ensuring prompt identification, treatment and management of long-term chronic disease. We want to ensure that people have access to preventive and supportive services and can readily access prompt diagnosis and treatment, with the goal of reducing the burden of disease and improve our population's health outcomes and quality of life.

Cardiovascular disease, Diabetes and Cancer – Despite having some of the lowest mortality rates from CVD (104.7 per 100,000 individuals) and Cancer (110.6 per 100,000 individuals) in the country, these chronic diseases contribute significantly to the overall burden of disease in our population. Cancer and CVD (including stroke) are responsible for nearly two out of every three deaths and significantly contribute to ethnic differences in health outcomes. Diabetes exacerbates the burden of many diseases, including CVD and with an estimated prevalence of 4.6 % (age-standardised prevalence, NZ Health Survey) and rising, will likely impact significantly on health outcomes into the future.

While over 90% of eligible adults have had their CVD risk assessment within the past five years, approximately half of eligible CVD patients are on triple therapy. Evidence suggests that this combination of pharmacological agents can reduce the five year ischaemic event rate by 25-30%. Cancer screening rates are high in our population, however inequalities and access barriers exist.

In 2015/16 our focus is to provide timely cancer identification and treatment and ensure patients with a high suspicion of cancer wait no more than 62 days from the date of referral for their first treatment. We are committed to applying the Equity of Health Care for Māori framework when reviewing or developing cancer pathways. In the area of cardiac and stroke services, our focus is to improve the pathways of care ensuring the provision of clinically appropriate, timely and equitable levels of access, including redesigning rehabilitation programmes. This will include working regionally to manage acute patient flow, to minimise patient wait times and refine transfer processes. Diabetes is a key priority for our District Alliance. Our focus is on identifying at-risk individuals early and improving diabetes management by providing culturally appropriate Healthy Lifestyle Programmes and supporting better self-management.

Mental Health Services –Māori and Pacific are particularly affected by mental health conditions. Our population experiences more positive mental health than New Zealand as a whole, however, one in eight people living in the district suffers from some form of mental illness with 3.5% using secondary mental health services. Waiting time targets (80% of people seen within 3 weeks, 95% within 8 weeks) have been exceeded for all services. Access rates for Māori youth reached 5.1% and 3.0% for youth overall. Access rates for older adults reached 4.6% and 3.6% for adults overall.

In 2015/16, we will focus on ensuring better integrated Mental Health and Alcohol and Drug services across primary and secondary care and review and develop our pathways of care to better meet the needs of specific population groups. We will submit the ADHB Suicide Prevention and Postvention Action Plan (2015-2017) to the Ministry of Health by 20 July 2015 and deliver on the 2015/16 actions of this plan. Non-government organisations (NGOs) in the mental health and addictions sector are important partners in the delivery of services within the community. We will enter into a collaborative approach with mental health and addictions NGOs to look at their sustainability. This will include service reviews and redesign to achieve appropriate performance and outcomes along with ensuring value for money and long term NGO sustainability.

Long-Term Conditions (LTCs)

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Prevention
• Fully utilise the Green Prescription programme 2015/16, especially focusing on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016
• Undertake a review of the existing retinal screening services across ADHB and explore options for an improved, patient-accessible service for Auckland DHB by June 2016.
 	
Identification of risk
• General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals who are at risk of developing LTCs – ongoing.
 	
Management
• Develop a detailed investment plan supporting the implementation of new models of care and services closer to home for diabetes and CVD (aligned to the ALT work plan) by June 2016
• Fully utilise self-management workshops with particular focus on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016
• Monitor and report on key indicators (by ethnicity) for the management of diabetes and CVD as prioritised by the District Alliance at the PHO level by December 2015 and at the practice level by June 2016
• Provide monitoring of the clinical indicators to the Metro Auckland Clinical Governance Forum – ongoing
• Establish Service Level Alliance (under the ALT) for diabetes and CVD by December 2015.
 	
Enablers
• PHOs will support the primary care workforce by providing appropriate education programmes - ongoing
• Implement information technology enablers, i.e. e-shared care and e-referrals – ongoing
• Establish quarterly reporting on key diabetes/CVD indicators, implemented by June 2016:
  ○ Percentage of people with diabetes that have uncontrolled high blood pressure (BP)
  ○ Percentage of people (with / without diabetes) aged <75 with a 5 year CVD risk >15% and < 20% on dual therapy
  ○ Percentage of people with diabetes who have appropriate management of micro albuminuria.
	• Provide 6,900 people with the opportunity to participate in the Green Prescription programme over 2015/16
	ASH rates
	• 0-4 years Total: TBC%
	• 0-4 years Māori: TBC%
	• 0-4 years Pacific: TBC%
	• 45-64 years Total: TBC%
	• 45-64 years Māori: TBC%
	• 45-64 years Pacific: TBC%
	• 0-74 years Total: TBC%
	• 0-74 years Māori: TBC%
	• 0-74 years Pacific: TBC%
	
	• Number of patients with diabetes (by ethnicity) who successfully complete self-management workshops
	
	• Maintain quarterly reporting on key diabetes/CVD indicators:
	  ○ Percentage of people with diabetes who have good or acceptable glycaemic control
	  ○ Percentage of people (with / without diabetes) who have had a CVD event and are on triple therapy

More Heart and Diabetes Checks

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

• PHO and general practice service agreements and activities will reflect the requirement to ensure that 90% of the eligible population, particularly at risk populations (Māori, Pacific and Asian men aged between 35 and 44 years) have their cardiovascular and diabetes risk assessment completed every five years – ongoing
• General Practices will use appropriate risk assessment, patient management and monitoring IT tools to identify individuals with CVD risk >15% and put in place appropriate management plans – ongoing
• Report on key CVD indicators (by ethnicity) as prioritised by the District Alliance at the PHO level by December 2015 and at the practice level by June 2016
• Implement information technology enablers i.e. e-shared care and e-referrals – ongoing
• PHOs will support the primary care workforce by providing appropriate clinician education programmes - ongoing
• PHO Quarterly Performance Monitoring Returns will include achievement against target and progress on specific actions/issues/risks/mitigation including quality improvement initiatives – ongoing
• Commitment of budget 2013 funding for PHO practice support/liaison team who assist practices with:
  ○ identifying eligible population and provide optimal management, as appropriate, of modifiable risk factors, namely lipid profile and glycaemic control
  ○ providing continued professional education on the quality standards for the optimal management for patients with Diabetes and high cardiovascular risk profiles
  ○ conduct audit and running practice level reporting to demonstrate improvement in patient care.
	• 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years

Diabetes Care Improvement Packages (DCIP)

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Prevention • See Long-Term Conditions section above. ***Identification*** • General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals who are at risk of developing diabetes and put in place appropriate management plans to delay or prevent the onset of the disease – ongoing • General practice will use tools (as above) to identify individuals with diabetes and put in place appropriate	• Reduction in the proportion of patients with HbA1c above 64, 80 and 100 mmol/mol, including those at high risk (e.g. Māori, Pacific, low decile, migrant and refugee populations), to be assessed quarterly • Number of patients with diabetes (by ethnicity) who successfully complete self-management workshops

Diabetes Care Improvement Packages (DCIP)	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

management plans (including care planning) to prevent or delay the onset of diabetes-related complications respectively – ongoing
• Pilot a mobile diabetes screening service targeted at high risk populations (including evaluation) by June 2016.
 	
Management
• Develop a detailed investment plan supporting the implementation of new models of care and services closer to home for Diabetes and CVD (aligned to the ALT work plan) by June 2016
• Provide access to self-management workshops with particular focus on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016
• Explore ways to improve participation in these workshops, particularly high needs populations, and develop a set of recommendations by June 2016
• Staged implementation of the Auckland/Waitemata Alliance Leadership Team (ALT) approved set of 22 diabetes care clinical indicators (based on the MoH 20 quality standards for diabetes care) – first five to be implemented by June 2016
• Provide monitoring of the above clinical indicators (by ethnicity) to the Metro Auckland Clinical Governance Forum – ongoing
• Maintain specialist support in primary care – ongoing
• We will continue to provide type one diabetes services for both Waitemata and our own populations and will review these services, particularly for youth, to determine if there is appropriate clinical and educational support for effective identification and management by June 2016
• Providers to demonstrate ongoing proactive management of patients with diabetes and/or CVD, with particular focus on at risk populations through quarterly Performance Monitoring Returns
• Work with Podiatry NZ to put in place (by June 2016):
  ○ a governance framework
  ○ a process for audit and accreditation
  ○ ongoing education package
  ○ a revised service delivery model that meets the needs of patients and whānau.
 	
Enablers
• Implement information technology enablers i.e. e-shared care and e-referrals – ongoing
• Support general practice with appropriate clinician education programmes – ongoing
• The Alliance working group/s will seek appropriate consumer representation from the Auckland DHB Consumer Panel as	

Diabetes Care Improvement Packages (DCIP)	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
required when undertaking service reviews/ redesign /development – ongoing.	

Cardiac Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Cardiac patients will be assessed using the national CPAC tool, treated according to assigned priority and time waiting and operated on within nationally agreed urgency timeframes - ongoing • Audit of selected patients who have been prioritised for surgery using the CPAC tool to assess correct use of tool – completed by November 2015 • Work with regional colleagues to manage the acute patient flow to minimise patient wait time and refine transfer process using the CPAC tool, to be regionally agreed to and applied by June 2016 • Audit existing referral pathways to cardiac rehabilitation programmes by ethnicity – audit complete by December 2015 • Define improved pathway to cardiac rehabilitation programmes and expected outcomes by June 2016 • Establish a best practice (using a whole-of-system approach, including primary care), regionally consistent Cardiac Rehabilitation Programme – by June 2016 • Measure retention rate on current cardiac rehabilitation programme to enable comparison once new programme established – by September 2015 • Continue to work on improving systems for data input and recording for cardiac registry data – ongoing • Work with the regional, and where appropriate, national, cardiac networks to improve outcomes for patients with heart failure (MoH new priority).	**Secondary Services** • Agreement to and provision of a minimum of 250 total cardiac surgery discharges for by July 2015/16 • Patients wait no longer than four months for first specialist assessment and treatment • 95% of patients with accepted referrals for elective coronary angiography receive their procedure within 90 days (currently at 100%). *Standardised Intervention Rates* • Cardiac surgery: 6.5 per 10,000 of population • Percutaneous revascularisation: 12.5 per 10,000 of population • Coronary angiography: 34.7 per 10,000 of population • The waiting list for cardiac surgery remains between 5 and 7.5% of annual cardiac throughput, and does not exceed 10% of annual throughput • Cardiac surgery patients are operated on within nationally agreed urgency timeframes. **Acute Coronary Syndrome** • 70% of patients will receive an angiogram within 3 days of admission - reported by ethnicity • Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days • Over 95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data within 30 days of discharge • Maintain the requirement that 70% of all ACS patients receive a coronary

Cardiac Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
	angiography within 3 days (86.6% at Q2, 2014). **Heart Failure** • Monitor readmit rates by NHI for heart failure patients to secondary services over the 12-month period.

Stroke Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• Run the 4th Stroke Education Day in September 2015, for health professionals involved in the care of people with stroke across the Auckland/Northland region
• Fully implement and refine a new care pathway for people admitted to the acute stroke unit, incorporating care management plans and lead clinicians, by December 2015
• Develop a proposal – including workforce requirements – to be submitted to the Regional CPC by July 2015, for enhanced regional access to neuro-interventional stroke treatment such as intra-arterial clot retrieval, with Auckland DHB as the tertiary treatment centre
• Consultation on a proposed all age stroke service will be completed by September 2015
• Establish all age (adult) community rehabilitation interdisciplinary service for early, active rehabilitation, based on need rather than age criteria - fully operational by June 2016
• Respond to ethnic disparities in stroke burden by investigating possible causes of premature stroke in Māori and Pacific people – investigation completed by June 2016
• Set up a mechanism to capture data measuring the time from hospital discharge to commencement of community rehabilitation (face-to-face visit) for patients with stroke who require ongoing rehabilitation by December 2015
• Develop and implement a stroke care competency education programme for nursing and allied health by June 2016
• Develop and implement a stroke thrombolysis care competency programme for medical and nursing staff, as part of the regional forum by June 2016
• Consider the outcomes of the Waikato Fast Campaign pilot for local application in 2016/17
• Participation in national/regional stroke networks – ongoing
• Participation in national/regional stroke networks, quality improvement and monitoring work – ongoing.
	• 80% of patients admitted to an acute stroke unit
	• 8% of acute ischemic stroke patients will be treated with thrombolysis
	• 80% of people with stroke requiring inpatient rehabilitation will be transferred within 10 days (the MoH requirement of establishing a baseline in 2015/16 has already been achieved)
	• 60% of nursing and allied health staff will have completed a stroke care training programme by June 2016
	• 80% of medical and nursing staff involved in the delivery of stroke thrombolysis will have completed the basic stroke training programme by June 2016
	• Collect data to establish a baseline for ongoing reporting of:
	  ○ The percentage of patients admitted with acute stroke referred to community rehabilitation
	  ○ The percentage of the above patients undergoing face-to-face community assessment within 5 days of discharge from hospital.

Note: regional imperatives will be met from current budget; no additional budget allocations will be made.

Faster Cancer Treatment

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Identify existing models/processes of investigations and treatment which negatively impact on faster cancer treatment times and implement changes recommended by local and regional cancer round one improvement projects to improve performance by June 2016 • Understand and manage radiotherapy and chemotherapy requirements through production planning and monthly monitoring in 2015/16 • Support the national workforce initiatives being undertaken by the Radiation Oncology Work Group and Health Workforce NZ to train more radiation technicians – ongoing • Build capacity through more efficient chemotherapy pathways including dose banding and oral anti-cancer agent management in 2015/16 • Ensure that all tumour streams have high suspicion flags which are used actively by the clinicians by December 2015 • Review care coordination and navigation arrangements, and develop a system wide plan with an emphasis on Māori, Pacific and Asian populations by December 2015 • Complete a FCT project to improve the medical oncology production planning by August 2015 • Align with and support the regional projects to progress the faster cancer target in all Northern DHBs in 2015/16 • Explore CT Lung cancer screening in primary care with a focus on achieving high screening rates and follow up rates for Māori and Pacific at risk by June 2016 • Collaborate with Primary Health Care providers encouraging the use of e referrals for cancer – ongoing • Develop a quarterly cancer equity report which includes indicators by ethnicity by December 2015 • Complete MDM stocktake by July 2015 • Develop local MDM protocols by December 2015 • Improve the functionality and coverage of MDMs utilising a coordination role, in place by June 2016 • Support the NCN conducting at least 2 additional tumour type reviews against national tumour standards by June 2016 • FCT pathway working group will identify and apply learnings to review tumour stream pathways – ongoing • Implement and support the Cancer Health Information Strategy when released nationally by June 2016 • Implement the Ministry-funded Cancer Supportive Care suite of psychological and social services to improve cancer patient support by June 2016 • Provide staff inputs and other resources to support round 2 of the bowel screening pilot for 2015/16 • Implement guidance on active surveillance treatment for prostate cancer care (available mid 2015), ensuring clinicians	• 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017 • Less than 10% of the faster cancer treatment records submitted by the DHB are declined • 100% of patients will receive their radiotherapy and chemotherapy within four weeks of decision to treat every month throughout the year • 60% of patients for a surveillance colonoscopy will have their procedure within 84 days of referral

Faster Cancer Treatment

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
receive information and care pathways and MDM proformas are updated.	

Rising to the Challenge/Mental Health and Addiction Services

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Adult Services
Integration of Services in the Community
• Participate in the pilot activities in the Tamaki Locality Plan, focusing on integration with primary care and NGOs - ongoing
• Stepped care model (specialist services):
  ○ Implement the Stepped Care model in one community mental health centre by June 2016
  ○ Pilot an alternative model of Adult Community Mental Health service working collaboratively with NGO(s) as part of the Stepped Care implementation by June 2016
  ○ Define and collect specific outcome measures by June 2016
• Build on primary and secondary integration by:
  ○ Implementing updated funded GP visit pathways by December 2015
  ○ Testing GP Clozapine pathway protocols by December 2015
  ○ Reviewing and roll out the GP Clozapine prescribing pathway by June 2016
  ○ Piloting and evaluating a shared primary/ secondary referral triage process with 1 PHO in 1 locality by June 2016
  ○ Ensuring community mental health clients enrolled with a GP have a discharge letter to the GP by June 2016.
System Redesign and Service Effectiveness
• Complete Community Acute Service redesign implementation by December 2015.
	• Continue to meet mental health and addictions service waiting times: 80% within 3 weeks and 95% within 8 weeks (PP8) with a special focus on 0-19 age group
	• Improve performance against access rate targets
	• At least 95% of Māori and Pacific long-term clients will have up-to-date relapse prevention plans
	• 50% of Māori and Pacific people in adult services, who meet the criteria, will have the lipid algorithm by June 2016
	• 85% of community mental health clients enrolled with a GP will have a letter to the GP within one week of discharge
	• All 8 Rising to the Challenge Service Development Plan actions for 2015/16 will be achieved

Understanding and boldly acting on inequities
• Run focus groups with Tangata Wai I te Ora and whānau accessing mental health services to gain insights into the negative and positive effects of compulsory community treatment orders by March 2016
• Monitor and analyse section 29 Mental Health Act treatment orders for Māori to identify trends by ethnicity by June 2016
• Implement reliable collection method of seclusion and restraint data for Māori and analyse the data to understand differential rates of use for Māori by December 2015
• As Māori and Pacific service users have the highest physical health co-morbidity rates, we will implement the lipid algorithm for clients who meet the criteria in each adult team with priority focus on Māori and Pacific clients by June 2016
	• Monitor and analyse section 29 Mental Health Act treatment orders for Māori:
	  ○ Record the number of CTOs (including indefinite CTOs) by ethnicity – quarterly
	  ○ Record the duration of CTO orders by ethnicity – quarterly
	  ○ Record the number and average length of admission by ethnicity – quarterly

Rising to the Challenge/Mental Health and Addiction Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• The joint WDHB/ADHB Employment Plan to increase access for service-users to employment will be released in March 2015. 2015/16 priority actions will be identified from the plan and implemented by June 2016
• A local implementation plan aligned with the Ministry of Health: Children of Parents with Mental Illness/Addiction (COPMIA) implementation guidelines (to be released in April 2015) will be completed by December 2015.
Child and Youth/REDS
Integration of services in the Community
• CAMHS will increase primary care liaison to support practice nurses and GP practices by March 2016
• Build Consult Liaison capacity over 2015/16 by refining clear definitions, continued staff training and benchmarking.
System Redesign and Service Effectiveness
• Implement new Eating Disorders Service Model by June 2016.
Older Persons
Integration of services in the Community
• Introduce a Shared care Plan to ensure that 95% of service users who have been in the service for two years or more will have up-to-date relapse prevention plans by June 2016.
System Redesign and Service Effectiveness
• Collaboration with Health of Older People to implement the Hospital Dementia Project by December 2015
• GP education sessions on the cognitive impairment pathway will be delivered by June 2016
• Appoint Mental Health Service for Older People liaison nurse specialist with designated accountability for dementia by December 2015
• Complete wait time project by December 2015
• Review triage and crisis pathways – by June 2016.
Suicide Prevention/Postvention
• Deliver the 2015/16 actions of the ADHB Suicide Prevention and Postvention Action Plan (2015-2017). The plan and actions will be guided by the Advisory Group and the Inter-Agency Working group:
  ○ workforce development training to identify, support and refer at-risk people, with a focus on youth/Māori
  ○ cross-agency facilitation in prevention and postvention.
Regional activity
• Participate in regional plan activity – High and Complex needs/Eating Disorders/ implementation of Perinatal and Infant Mental Health continuum/ Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and	

Rising to the Challenge/Mental Health and Addiction Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
forensics (youth and adult) – ongoing • Continue implementation of local Infant and Perinatal Mental Health Services – with year two of service development funding: $1,224,641. **NGO sustainability** • Work with Mental Health and Addictions sector NGO representative groups to plan for sustainable services – agree approach, work plan and milestones with NGOs by 31 December 2015.	

Timely and efficient access to services

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

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

In 2015/16, we will submit a redesign for the expansion of our emergency facilities and implement the ED quality framework. A number of pilot programmes are planned, including alcohol data collection and employment of a pharmacist within the department. We will implement additional local and regional pathways to improve patient flow.

Access to surgery and diagnostics – Providing our population with timely and equitable access to elective surgery and diagnostic services is a key priority. Compared with the New Zealand average, Auckland DHB residents have a lower rate of access to elective surgery, such as hip and knee replacements, hernia repairs and heart operations. The Auckland DHB also provides elective heart operations for Waitemata and Counties Manukau DHB residents.

In 2015/16, we aim to improve outpatient performance by using alternative follow-up methods and timely discharge to primary care. We want to increase the number of patients attending their appointments by understanding the reasons for non-attendance and developing tools and processes to alleviate this. For each cancer patient, we will monitor journey times through diagnosis and treatment. We want to enhance throughput in CT and MRI and ensure efficient use of capacity across all departments. We will establish a two-year capacity plan for Endoscopy services with a focus on achieving sustainable colonoscopy services.

Shorter Stays in Emergency Departments	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Orientate ED staff in engagement of Māori and cultural responsiveness by August 2015 • Implement pathways in collaboration with inpatient services to achieve more timely access to inpatient care and inpatient beds by June 2016 • Work with Radiology department to improve timeliness in	• Achievement of Shorter Stays in ED health target of 95%

Shorter Stays in Emergency Departments

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

access to diagnostics that aid a diagnosis, plan and destination decision by monitoring time to access – ongoing
• Complete implementation and measurement of ED Quality Framework:
  ○ Finalise report card by July 2015
  ○ Complete time to antibiotics in sepsis clinical audit by June 2016
  ○ Complete time to analgesia clinical audit by June 2016.
Adult Emergency Department (AED)
• Monitoring of ED quality framework patient journey indicators has identified delays in transfer of patients to wards from ED – work with clinical directors to improve the timeliness of review, acceptance and transfer of patients by June 2016:
  ○ Develop and embed an escalation pathway to improve timeliness of medical and surgical review of ED patients
  ○ Employ locum staff to cover identified peak periods in ED attendance
• Submit redesign/expansion proposal for Level 2 to the Board by July 2016
• Progress the patient flow project within the scope of facility design by June 2016
• Increased staffing (as per approved budget) in AED by July 2015
• Redesign area of ED to respond to emerging viral diseases-isolation technology and processes – by June 2016
• Monitor the trial of the accelerated chest pain pathway in ED during 2015/16 and commence evaluation by June 2016
• Develop regional pathways and after hours arrangements by June 2016
• Strengthening relationships with primary care with improved communication surrounding discharge documentation – ongoing
• Alcohol data collection pilot project completed by July 2015
• Green belt project to improve ED efficiency completed by October 2015
• Increase allied health presence in terms of OTs in ED/APU by June 2016
• Frailty pathway development- June 2016
• Pilot pharmacist in AED to improve prescribing and medication management, to commence in July 2015
• Implement Fractured Neck of Femur pathway by June 2016.	

Shorter Stays in Emergency Departments

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Children's Emergency Department (CED) • Implementation and measurement of ED Quality Framework: commencing with the mandatory fields by June 2016 • Collate data on the 1-hour transfer to inpatient bed process, review and make available to wards to assess individual performance by November 2015 • Appropriate non-nurse transfer from CED to wards commenced by November 2015 • Ensure that all eligible patients (including Māori and Pacific) are referred for the healthy homes initiative (monitored by audits) in 2015/16 • Child protection screen - all under 2-year-olds will be screened for concerns re: NAI from July 2015 • Increase nursing staff in CED as per approved budgeted by July 2015.	

Improved Access to Surgery

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Continue to investigate access issues for procedures where standardised intervention rates are less than the national average and put plans in place, as appropriate to address - ongoing • Delivering on gains achieved through Elective Surgery and Workforce Productivity Programme (ESPWP) funded initiatives - ongoing • Complete the rectal bleeding pathway changes to reduce time to diagnosis for patients by June 2016 • Maintaining gains achieved through ORL, Ophthalmology and Orthopaedic improvements - ongoing • Contribute to implementation of eReferrals and National Patient Flow data collection IT infrastructure locally and regionally – as required • Establish on call cover to support ADHB as single point of contact regional trauma centre by October 2015 • Resolve timely data entry into local Trauma registry by October 2015 • Implement a patient information directory and look at channels for delivery, such as social media, downloadable disks and infomercials – model in place by June 2016 • Pilot/implement Discharge Coordinators across Medicine and Surgery and build on pharmacist/MDT pre-admission clinic support model, including use of discharge medication 'bundles' – completed by June 2016 • Engage with Māori and Pacific Health services to develop	• Meeting the health target by delivering a minimum of 16,700 elective discharges by June 2016 • Compliance with the four month wait time for FSAs and elective surgery over the 2015/16 year • Volume of discharges delivered for other DHB populations is in line with funding agreements • Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions • Phase III Patient level data is being reported into the National Patient Flow collection, in line with specified requirements – by July 2015 **Standardised Intervention Rate Targets** • Major joint replacement procedures: 21/10,000 of population • Cataract procedures: 27/10,000 of population

Improved Access to Surgery

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
and implement plans to increase Māori and Pacific patients' access to bariatric surgery - plan developed by October 2015 and implemented by November 2015 • Fast track abnormal Uterine Bleeding patients to Outpatients rather than Inpatient hysteroscopy – fast track system in place by June 2016 • Bariatric surgery – please see the Obesity section.	

Note: regional imperatives will be met from current budget; no additional budget allocations will be made.

Improved Access to Diagnostics

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Adapt to the changes in reporting in regards to the implementation of phase three of the National Patient Flow by June 2016 • Provide representation, attend and participate in national and regional clinical group activities – ongoing • Participate in the National Radiology Service Improvement Initiative, with the continued implementation of the Service Improvement project (including Demand Management, and Improvements in Acute Diagnostic Flow, Patient Flow and Throughput and Reporting and Visibility work streams) – over 2015/16. **CT and MRI** • Further enhance patient throughput in CT and MRI, utilising capacity across all three departments by managing the capacity and demand data presented to the Capacity Planning meeting weekly – ongoing • Maintain six CTA-funded sonographer training positions. **Colonoscopy** • Establish a two-year capacity plan for Endoscopy services with a focus on sustainable colonoscopy services by September 2015 • Ongoing participation in regional collaborative activities and the development of a 5-year colonoscopy plan.	**CT and MRI** • 95% of accepted referrals for CT scans will receive their scan within 6 weeks • 85% of accepted referrals for MRI scans will receive their scan within 6 weeks **Colonoscopy** • 75% of patients accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks, with 100% within 30 days • 65% of patients accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks, 100% within 120 days • 65% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks beyond the planned date, 100% within 120 days

Financial Responsibility

We must ensure we are on a sustainable financial path into the future. However, this will be extremely challenging in the current fiscally constrained environment that is also characterised by increasing demand for services (reflecting our population demographics) and operating costs and capital related costs growing at a pace faster than the funding growth.

The funding we receive from government needs to cover health and disability services across the system – from primary prevention work in the community through to specialist services in the hospital. On top of our Funding Envelope, our DHB gets paid for the work we do for patients referred from other DHBs. The amount we are paid for some of our high cost specialist work does not cover the full cost of the treatment. Over half of our work is for patients who live outside of our district. Although these prices are set nationally, the pricing model has left us having to offset national work from funds that are earmarked for our own population. As a hospital of last resort, Auckland takes patients from all over NZ and the Pacific and carries the greatest burden for the costs associated with specialist interventions. With our regional partners we will establish the right mix and configuration of specialist work for our region, and will also support the national work on specialist services and price.

For 2015/16 one of our key priorities is to continue with a business transformation framework for long-term financial and service sustainability in line with our strategic plan. With the established single point of accountability, we now have an enhanced clinical leadership model to improve patient experience, enhance quality and safety outcomes and deliver healthcare services more efficiently. Some work currently done in hospital could be managed within primary care. Genuine collaborations across primary and secondary care will lead to models of care that reduce reliance on hospital services. Many hospital admissions and re-admissions point to us missing problems at an early stage. We want these problems managed earlier by the person's GP. All DHB staff need an understanding of basic improvement science to help get the best value from our resources.

Financial Responsibility	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
The business transformation programme will continue into 2015/16 and beyond. The key areas of focus of this programme, to be delivered by June 2016, will include the following: • Implementation of service delivery models including system-wide design and appropriate purchasing of services for Older People, Mental Health and Children's Services • Reviewing and implementing medical personnel skill mix changes across the organisation to achieve improved efficiency and productivity – on-going • Reconfiguring the surgical services model, including enhancements to production planning and improved utilisation of theatres • Implementing Support Service agency savings from procurement, inventory control and back-office efficiency initiatives (NZHPL, healthAlliance) • Pharmac and healthAlliance are working jointly on the national procurement of medical devices for best health outcomes – on-going	• Increase in other revenue streams through commercial contracts, research funded studies, bequest programme, collaboration in research service with other DHBs, systems improvement – increases realised by June 2016 • Continue to work with the National Health Board in the 2015/16 year to ensure a sustainable model for tertiary services • Continued development of region-wide service delivery models by June 2016 • Delivery of targets described in regional work-streams in 2015/16 by June 2016 • Training posts and associated costs identified and mitigated by June 2016 • Maintaining the capped FTE levels agreed in the Annual Plan for non-

Financial Responsibility	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Implementing revenue generation strategies through commercially funded research studies, service contracts, bequest programme, sharing research service, research cash-flow timing, systems control among other clinical and non-clinical revenue generation strategies • Funder service review • Continuing to work with other DHBs to define the tertiary services they wish to have provided for their populations and the cost they wish to pay. Match service delivery to income. Work within the Northern region to determine the most clinically appropriate and cost effective pattern of service provision to meet patient need and access • Working with the National Health Board and Ministry to determine the specifications of national services matched to financial allocations on-going • Supporting the work of NZHPL to develop a business case aimed at reducing the costs of food, linen and laundry services while improving the overall quality and provision of these services • Support the NZHPL development of the detailed National Infrastructure Platform business case and provide input as required and as appropriate. Commitment of resources is subject to Board decision on the completed business case • Ongoing review of the capacity to maintain the level of training posts within the DHB • Implementing clinical support service efficiencies in Laboratory, Radiology etc.	clinical staff – ongoing • Detailed savings included in the Auckland DHB financial budgets (with monthly phasing) will be reported to the NHB on a monthly basis

3) Elevating quality and safety

Provide high quality and safe services

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

Patient safety is the cornerstone of high quality health care. Our performance within the key quality and safety markers has improved over time, but we aim to continue to reduce hospital adverse events, such as falls and infections. We have improved our rates of compliance with good hand hygiene practice from 70% (July-October 2012) to 76% (July-October 2014), and are tracking with the national average; however, this remains an area for improvement. Central line infections in our intensive care unit (ICU) are very rare events, and we have achieved consecutive months without any central line infection in our ICU. We have a 'Falls and Pressure Injury' governance group in place which has a community falls workstream, an aged residential care workstream and a hospital provider arm workstream. We have decreased the number of patient falls resulting in major harm from 1 per 5,000 bed days to less than 1 per 10,000 bed days. This strong result is partly due to over 93% of elderly patients now assessed for their risk of falling and those at risk having a falls care plan in place.

In 2015/16, we aim to improve a number of processes across our quality and safety work with the goal of improving our performance across the various quality and safety markers. We aim to improve medicine safety by mapping our medication pathways to identify interventions that enhance safety, processes, patient information and experience, and introduce electronic prescribing and administration. We will continue our collaboration with the regional and national patient safety programmes, including the First Do No Harm and Open for Better Care programmes.

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Embed ICNet over 2015/16 – provide greater access to data, simplify reporting and increase measurement across the organisation - implementation to begin May 2015 • Sustain the safety improvement gains achieved through implementation of the First Do No Harm patient safety programme and continue regional collaboration on key patient safety areas - ongoing • Collaborate in the regional transition from the First Do No Harm programme to active participation in and implementation of the national HQSC Open for Better Care campaign – ongoing • A new quality IT system to support our patient safety and clinical governance activities, with implementation to start from December 2015 • Roll out a Clinical governance framework for each directorate by October 2015 • The falls with serious harm adverse event review sub-committee will continue to review care and practice for all hospital falls with serious harm and identify areas for improvement - ongoing • Falls risk assessment and care planning is audited monthly	• Achieve and maintain 80% hand hygiene compliance by June 2015 and increase engagement with the medical staff to lift performance (monitored by monthly local audits) • CLAB – insertion compliance at >90% and our rate at <1/1000 days. Focus will move to the areas beyond ICU, e.g. renal, haematology and general surgery • 98% of older patients are given a falls risk assessment and patients at high risk of falling have a falls care plan in place • Meet the HQSC standard for direct observational audit of the use of the surgical safety checklist • National SSI improvement programme – meet the QSM for the process measures for orthopaedics. Achieve a significant reduction in SSI

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

with results reported by ward / department through the use of pareto charts - ongoing
• Rollout of falls module of accelerated Releasing Time to care toolshed - completed within 8 inpatient areas by June 2016
• Hand Hygiene:
  ○ All clinical areas will have trained gold auditors reporting into the Auckland DHB national reporting data by December 2015
  ○ A monthly report of the number of moments audited and the compliance rate will be presented at the Infection Prevention and Control Committee, commencing July 2015
  ○ Directorate Leaders will be responsible for ensuring that there is engagement within their areas is in place by September 2015
• Undertake monthly observational audits of the use of the surgical safety checklist by each specialty group to ensure the checklist is being used as a teamwork and communication tool - ongoing
• Introduce team briefing and debriefing for each operating theatre list to improve patient safety, teamwork and communication within the teams by June 2016
• Work with the Health Quality and Safety Commission (HQSC) to implement the new perioperative harm quality and safety marker during 2015/16, for public reporting in 2016/17
• Sustain achievement above the identified Quality and Safety Marker threshold for the clinical standards specified by the national Surgical Site Infection Improvement Programme (SSIIP) for hip and knee operations - ongoing
• Continue to work with the Anaesthetic Department to improve adherence to the prophylactic antibiotic (cefazolin) protocols of the SSIIP and to ensure that private providers performing DHB-funded surgery in the private sector also adhere to the protocols - ongoing
• Continue to audit the appropriate dose and timing of the administration cefazolin antibiotic, and appropriate skin preparation, for hip, knee and cardiothoracic surgery and track and report the results – ongoing
• Introduce SSI surveillance for cardiothoracic surgery procedures by December 2015
• Map medication pathways (covering all appropriate medications in each pathway)
  ○ to be completed in Adult Medicine and Surgical Directorates by September 2015
  ○ agreement on action plan by March 2016
  ○ implementation to begin by June 2016
• Rollout medicines reconciliation across the organisation:
	rate:
	  ○ Antimicrobial Prophylaxis – 95% of hip and knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis
	  ○ Antimicrobial timing – 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision
	  ○ Correct duration - prophylaxis is discontinued within 48 hours of surgery
	  ○ Appropriate skin antisepsis – 100% of hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/ povidone iodine
	• Cardiac surgery to meet the QSM measures (as listed above) at a similar level as orthopaedics
	
	>90% of deaths in surgical services will undergo a structured review

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
○ Identify roles, responsibilities and resource implications by September 2015 ○ Complete an action plan(including admission, transfer and discharge action – both paper based and electronic), to include e-medicines recommended implementation timeline by December 2015 ○ Implementation to begin by March 2016 • Introduce electronic prescribing and administration - develop a business plan and implement in two wards by November 2015 • Update RMPro by December 2015: ○ Directorate Governance Structures by December 2015 ○ Implement scorecards and reporting by March 2015 • Improve mortality review systems including standardisation of review processes, case selection and documentation by June 2016 • Establish a screening process for all medical service deaths to identify those for formal review by June 2016 • Continue to actively participate in the National Opioid Collaborative – ongoing • Implement a risk-based approach to learning from adverse events and corrective actions by January 2016 • Implement a risk assessment tool for VTE in adult inpatients by March 2016 • Establish a baseline for the Vapourised Hydrogen Peroxide systems for the purpose of reducing the likelihood of MDRO and VRE by June 2016 • Annual Quality Accounts produced in 2015/16 will be informed by HQSC guidance and will be focused on whole-of-system performance and continuous quality and safety improvement.	

4) Collaboration, innovation and high quality communication

Provide care in the most appropriate setting

With the right processes and support many people can manage their health and long term conditions in the community. There is significant opportunity to expand our primary and community services to rebalance the system, enhance the collaborative ties between community health and hospital services and provide services that are more responsive to people's needs.

We know there are services we currently deliver in our hospitals that could be delivered in the community and we will work collaboratively across the system to redesign and develop innovative and sustainable models of care around the patient. Collaborative partnerships across community health and hospital services will help to get the right mix of services and in the right place.

Primary Care – Primary care is central to improving health and reducing inequalities: 90% of our population's interactions with the health system occur in primary care and it is often the point of entry into the health system. A more integrated system where primary and secondary care clinicians work collaboratively with clear and open lines of communication will ensure that appropriate healthcare services are delivered in the right place at the right time. Over the previous year, we have made strong progress in achieving the primary care targets. We have continued to improve the relationships between the DHB and primary health care. The Auckland and Waitemata District Alliance is in place with a focus on patient and whānau determined care, improved integration, long-term conditions and building capability and capacity in primary care.

In 2015/16, we will continue to focus on developing and strengthening our alliance with our primary care partners and improving the management of diabetes and long-term conditions in primary care. We are committed to working with PHOs to explore opportunities to develop a comprehensive approach to developing the capacity and capability of general practices and to jointly implement the Integrated Performance and Incentive Framework - with the aim of improving performance within the primary care health targets.

Primary Care/Integrated Performance Improvement Framework

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Primary Care
• Review Auckland and Waitemata District Alliance to identify improvement opportunities by 31 December 2015 (this will include alignment of all current Service Level Alliances – Rural, After-Hours, Pregnancy and First Year of Life, Youth and Rheumatic Fever)
• Rural funding will be allocated as per the historical/current arrangements in 2015/16
• The Rural Alliance work programme will consider rural funding allocations:
  ○ review completed by December 2015
  ○ implement updated rural funding allocation plan by March 2016
• Review Metro Auckland Regional Clinical Governance Forum to identify improvement opportunities by 31 December 2015
• Work with PHOs to jointly achieve the primary care Health Targets (see relevant sections for specific activities and timeframes)
• Maintain ongoing rates of direct access for general practitioners to a full suite of diagnostic imaging including X-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI via:
  ○ Hospital-based radiology service – ongoing
  ○ Access to diagnostics programme (community-based radiology services) - ongoing
• Work with PHOs and regional Primary Options for Acute Care (POAC) members to continue to support the services across Auckland – ongoing
• Support the implementation of free under 13's for free general practice visits, prescription co-payments (daytime
	• Achievement of the primary care health targets:
	  ○ 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years
	  ○ 95% of 8 month old children will be fully immunised
	  ○ 90% of patients who smoke and are seen by a health professional in primary care are offered brief advice and support to quit smoking by June 2016
	• Maintain direct access of at least:
	  ○ 19,802 community referrals (2014 baseline) to the hospital-based radiology service
	  ○ 3,473 community referrals (2014 baseline) to the Access to Diagnostics Programme (community-based radiology services)
	• Implementation of free visits and prescriptions for under 13s from 1 July 2015 and After Hours from October 2015 (aligned to the After Hours procurement process)
	• 95% of new-born's receive all scheduled immunisations by 8 months of age
	• 95% of new-borns receive all

Primary Care/Integrated Performance Improvement Framework	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

and after hours)
• Implement information technology enablers:
  ○ e-shared care - ongoing
  ○ e-referrals – ongoing
• Implement and support the National Enrolment Service implemented by June 2016
• Ensure that General Practice implement identified quality improvement activities based on the results of the Ethnicity Data Audit Toolkit - ongoing
• Support the implementation of the Community Pharmacy Services Agreement through engaging primary care prescribers and hospital services with pharmacy. Extension to the existing contract to be finalised by 1 July 2015.
• Complete pilot of Diabetes Quality Improvement Team by 30 June 2016
• Palliative care model:
  ○ Agreed Implementation plan by 31 December 2015
  ○ Implementation of Medical Hub by 30 June 2016.
 	
System Integration/ Effective and Coordinated Services Closer to Home
• Work with PHOs to investigate supporting the health care homes model in agreed demonstration sites:
  ○ Present a proposal of jointly-agreed scope to Alliance Leadership Team (ALT) for consideration by end of Q2 2015/16
  ○ Explore the opportunity to run a demonstration programme of the Health Care Home concept in at least one area with a high needs population and where access to primary care is limited – feasibility study initiated by March 2015
  ○ Pending outcome of feasibility study, decision made by ALT by June 2016
• Continue investment in the following areas:
  ○ Primary Options for Acute Care (POAC)
  ○ Access to diagnostics
  ○ After hours services
• Clinical pathways:
  ○ Mental Health developed by December 2015 and in place by March 2016
  ○ Diabetes developed by June 2016
• Expand the Safety in Practice programme to 10 more general practices in the Auckland district from July 2015
• In collaboration with primary care we will develop an interdisciplinary and integrated (with general practice and other community services) model of care for DHB community services delivery by September 2015
• In collaboration with primary care we will implement the
	scheduled immunisations by 2 years of age

Primary Care/Integrated Performance Improvement Framework	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

interdisciplinary and integrated model of care by June 2016
• Revised sexual health service delivery model from July 2015
  ○ Up to 30% of the service will move to general practice
  ○ Standardisation of access to free services for young people
• Develop business cases for provision of improved access to community delivered services:
  ○ cognitive impairment services (based on the model of care developed with general practice) by December 2015
  ○ Infusion services such as ferinject by March 2016
• Review existing resourcing of diabetes services by March 2016
• Develop a plan to maximise the delivery of diabetes services in the community setting – including improved access to community podiatry and retinal screening:
  ○ work plan to be finalised by September 2015
  ○ delivery of work plan by June 2016
• Co-ordinated Care, assessment, rehabilitation and Education (CARE) pilot enrolling patients by July 2015 – this is also a target for Health of Older People
• Continue the development of clinical pathways that include Primary Care direct and easy access to specialist nurse/and or doctor advice in the following services by June 2016:
  ○ Mental health
  ○ Diabetes (aligned to the ALT workplan)
• Work with the Auckland Regional After-Hours Network to implement the new after-hours, over-night, and GP deputising services by 31 December 2015
• Develop a plan for the implementation of the National Access Criteria for Community Referred Diagnostics by June 2016
Integrated Performance Incentive Framework
• Work with PHOs to jointly implement the Integrated Performance and Incentive Framework - ongoing (see relevant sections for specific activities and timeframes)
• Implementation of the Health Quality and Safety Commission Patient Experience Survey (once developed).	

5) Holding people, systems and structures to account

Healthy and engaged workforce

We have over 10,000 staff with a tremendous diversity of skill and culture. We need to develop our people – establish a culture that lives our values and ensure they are healthy and engaged.

Regardless of the size and complexity of our organisation, it is vital that we make changes, and at a pace to meet demand, while at the same time being mindful of our important national teaching and training responsibility. Staff need a clear direction for the future, clear expectations and accountabilities, and a work programme aligned with sour vision and values. It is important to have a strong sense of identity and foundation. Having a clear purpose and shared ways of working helps us measure and track results. We can do more to celebrate this characteristic of Auckland and see it as a strength. We are all accountable for modelling our organisational values. This will make for a better work environment for staff as well as patients.

Evidence suggests that patients' experience and the quality of health care they receive are influenced by the experience and the health and well-being of the staff providing that care. As such, enhancing staff experience along with ensuring their health and well-being is not only important in its own right but also for the quality of the patient experience and the quality of the care they receive.

In 2015/16, we will develop a programme to embed our organisational values and articulate what standards and behaviours are expected of our staff. We will continue to develop our healthy workplace initiatives to assist in the health and well-being of our staff. Cultural competency programmes will be further developed to assist in developing our staff to be multi-perspective and culturally responsive.

Healthy and Engaged Workforce	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

Values
• Develop a programme to embed organisational awareness of the new values and articulate what standards and behaviours are expected by October 2015.
Planning our future workforce
• Plan for our demographic and model of care changes for the future by using workforce intelligence and the forecasting tool developed by the National GM HR Group by June 2016.
Attraction and retention
• Develop healthy workplace activities and promote cultural diversity and support, including:
  ○ Provide an orientation day for new staff which includes input from He Kamaka Waiora (Maori Health service) and a cultural competence session - ongoing
  ○ Support the He Kamaka Waiora service - ongoing
  ○ Continue with the Rangatahi Programme
  ○ Continue with recruitment, retention, development and mentorship of the Pacific health workforce utilising the Pacific Nurse Educator
  ○ Continue to promoting Pacific health in the community with HVAZ initiatives and workplace wellness
  ○ Continue provision of A+ Trust scholarships for Maori
	• Grow the Māori workforce from 5.3% to 10% in all areas by 2020

Healthy and Engaged Workforce	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
and Pacific secondary students ○ Continue with the ANIVA Nursing Leadership programme funded by the MoH and contracted out to Pacific Perspectives ○ Expand the workplace wellness initiatives offered, including Heartbeat Challenge renewal, Feetbeat Challenge (September 2015) and a Wellness Fair in September 2015 • Contribute to the expansion and development of the Grow our Own initiative - support redesign of tools by June 2016. **Capacity and capability** • Ensure that Auckland DHB staff have the capacity and capability to achieve our strategic aims by undertaking a stock take of existing support programmes for unregulated workforces and identifying initiatives to support the capability of this workforce by November 2015 • Support cultural programmes for Māori, Pacific and Asian workforces that improve access/engagement and health outcomes including providing ○ Treaty of Waitangi and Tikanga in Practice workshops (9 of each workshop in 2015) ○ Cultural and Linguistic Diversity (CALD) workshops and e-learning modules (12 workshops scheduled in 2015). **Leadership and management** • Embed and improve the leadership culture at Auckland DHB whilst supporting the new operating model roll out by piloting the use of the Leadership and management Capability Domains Framework in the recruitment of senior leads in non-clinical roles by July 2015 • Support the Pacific Nurse Leadership Group in their advisory role to ADHB SLT through the Executive Director of Nursing • Participate in the HWNZ Leadership and Management Workstream – ongoing.	

MODULE 3: Statement of Performance Expectations

The statement of forecast service performance is a requirement of the New Crown Entities Act 2013. It identifies outputs, measures, and performance targets for the 2015/16 year.

A few cornerstone measures are chosen to cover the vast scope of business-as-usual activity. These provide a reasonable representation of the services provided by a District Health Board. They represent activities that deliver our goals and objectives in modules 1 and 2. They cover the quantity, quality and the timeliness of service delivery. Recent 'actual' performance data is used as the baseline for targets. Actual performance against these measures will be reported in our Annual Report, and audited at year-end by AuditNZ on behalf of the Office of the Auditor General.

Cost of outputs

Old Output Class Name	Public	Primary	Hospital	Support	Total
New Output Class Name	**Prevention Services ($'000)**	**Early Detection and Management ($'000)**	**Intensive Assessment and Treatment ($'000)**	**Rehabilitation and Support ($'000)**	**Total ($'000)**
Total Revenue	**23,430**	**450,426**	**1,358,447**	**200,640**	**2,032,944**
Expenditure					
Personnel	18,489	2,646	800,031	36,576	857,742
Outsourced Services	718	2	94,093	874	95,687
Clinical Supplies	303	79	233,799	4,916	239,097
Infrastructure & Non-Clinical Supplies	3,395	795	174,765	8,025	186,980
Payments to Providers	2,053	441,938	57,967	149,115	651,073
Total Expenditure	**24,958**	**445,460**	**1,360,655**	**199,506**	**2,030,579**
Net Surplus / (Deficit)	**(1,528)**	**4,966**	**(2,208)**	**1,134**	**2,365**

Targets and achievements

Auckland DHB's focus for 2015/16 is on making a positive impact on health outcomes; making sure people have a positive experience of our health services; and using resources efficiently. Our actions in 2015/16 need to contribute directly to the outcomes we want over the longer term. The outcomes and impacts in this section link to the national, regional and local strategic direction covered in Module 1 of this document.

The rationale and targets for each of the output measures is included in the following tables. When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was on target, was very close to target and where performance was less than expected.

The criteria used to allocate these grades are as follows:

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

*and improvement on previous year

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

Key to output tables

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

Output class 1: Prevention Services

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

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

Approximately a third of the burden of ill health is preventable and for some diseases such as cardiovascular disease the percentage is much higher. Effective prevention services can therefore have a significant impact on health outcomes. From a financial sustainability perspective, an expedient response to outbreaks, environmental hazards and other emergencies also reduces downstream demands on DHBs for personal health services.

Output: Health promotion

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking	Q	96.2%	95%	Q2 2014/15
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care who are offered brief advice and support to quit smoking	Q	97.7%	90%	Q2 2014/15
Number of people accessing Green Prescriptions	V	4878	6936	Q2 14/15 extrap.
Enforcement of the Smokefree Environments Act 1990				
Number of retailer compliance checks conducted	V	302	300	2013/14
Proportion of retailers visited during Controlled Purchase Operations (CPOs) in which tobacco is sold to minors	Q	3% (7 retailers)	Ω	2013/14

Output: Health protection

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Tuberculosis (TB)				
Number of TB contacts followed up	V	1,080	750	2013/14
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	83.6%	≥85%	2013/14
Percentage (and number) of eligible infants vaccinated with a BCG	C	98.3% (4,613)	≥98%	2013/14
Refugee health screening service				
Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule	C	99.6%	≥99%	2013/14

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

Output: Population-based screening

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Breast Screening				
Coverage rates among eligible groups (45-69)	C	68%	70%	Sept 2014
Newborn Hearing Screening				
Number/proportion of babies offered screened within 1 month	V	7948 (98%)	90%	CY2014
Referral rate to audiology ≤4%	Q	1.6%	≤4%	CY2014
Appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme.	T	100%	≥95%	CY2014
Children				
Percentage of B4 School Checks completed	C	94%	90%	Q2 2014/15 extrap.

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

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 PHOs, general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB area. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Early detection and effective management of disease can significantly improve outcomes for our population. Prompt diagnosis of acute and chronic conditions and management and cure of treatable conditions, contributes to safe and effective service delivery and an excellent patient experience. Early detection and management services also enable patient's to maintain their functional independence and prevent relapse of illness.

Output: Primary health care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Primary care enrolment rates	C	91.1%	95%	March 2015
Percentage of children fully immunised at 5 years	C	81%	90%	Q2 2014/15
HPV vaccination coverage (for dose 3)	C	76%	65% (for dose 3)	Dec 2014
Seasonal influenza immunisation rates – 65+	C	65%	75%	Q1 2014/15
Cervical screening coverage	C	79%	80%	Dec 2014
Percentage of diabetes patients receiving retinal screening	C	72%	72%	2014/15
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C	91.9%	90%	Q2 2014/15

Output: Community-referred testing and diagnostics

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Number of community laboratory tests	V	3,086,467	Ω	Oct 2013 – Sept 2014
Number radiological procedures referred by GPs to hospital	V	44,365	Ω	2013/14
Number of complaints ◈	Q	LTA = 60	Ω	2014
Average waiting time in minutes for a sample of patients attending collection centres between 7am and 11am	T	8.5	< 30 mins	Jan 2015
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 71% MRI 75%	CT 95% MRI 85%	Dec 2014

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

Output: Oral health

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Enrolment rates in children under five by ethnicity	C	75%	85%	Dec 2014
Utilisation rates for adolescents	C	84.8%	87%	CY 2013
Arrears rates by ethnicity	T	6.5%	7%	Jan 2015

Output: Pharmacy

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Number of prescription items subsidised	V	6,507,848	Ω	2013/14

Output Class 3: Intensive Assessment and Treatment

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

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

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

Effective and prompt resolution of medical and surgical emergencies and acute conditions leads to safe and effective service delivery and an excellent patient experience. It also reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life, thereby improving population health.

Output: Acute services

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Number of ED attendances	V	103, 540	Ω	2013/14
Acute WIES total (DHB Provider)	V	92,808	94,755	2013/14
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	Q	94%	95%	Q2 2014/15
Compliance with Faster Cancer Treatment national health target - 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016 (increasing to 90 percent by June 2017)	T	57.6%	85%	Q2 2014/15
Percentage of eligible stroke patients thrombolysed	T	8.1%	8%	Q1 2014/15
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Q	80%	80%	Q1 2014/15
Percentage of ACS inpatients receiving coronary angiography within 3 days	T	86.6%	70%	Q2 2014/15

Output: Maternity

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Number of births	V	7223	Ω	CY2013
Proportion of all births delivered by caesarean section	Q	34.7%	↓	CY2013
Established exclusive breastfeeding at discharge excluding NICU admissions	Q	79%	75%	CY2013
Third/fourth degree tears for all primiparous vaginal births	Q	3.5%	↓	CY2103
Admission of term babies to NICU	Q	6.0%	↓	CY2013
Number of women booking before end of 1st trimester.	Q	64%	80%	2012

Output: Elective (inpatient/outpatient)

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Delivery of health target for elective surgical discharges	V	New measure	16,700	
Patients waiting longer than four months for their first specialist assessment (FSA)	T	0	0	Jan 2015
Patients given a commitment to treatment but not treated within four months.	T	0	0	Jan 2015

Output: Quality and patient safety

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Q	0.25	↓	CY2014
Percentage of respondents who rate their care and treatment as very good or excellent (ADHB only)	Q	84%	↓	Feb 2014-Jan 2015

Output: Assessment treatment and rehabilitation (inpatient)

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
AT&R bed days	V	24,119	Ω	2013/14
Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	T	88%	90%	2013/14

Output: Mental health

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Improving the health status of people with severe mental illness				
Access to mental health services 0-19 20-64 Over 65	C	 3.01% 3.84% 3.55%	 3.0% 4.0% 4.0%	Jan-Dec 2014
Improving mental health services using transition (discharge) planning and employment				
Child and Youth with a Transition (discharge) plan.	Q	82.9%	95%	Q2 2014/15
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.				
% of clients seen within 3 weeks - Mental Health - Addictions % of clients seen within 8 weeks - Mental Health - Addictions	T	 87.9% 84.1% 96.4% 93.9%	 80% 95%	Oct 2013-Sept 2014

Output class 4: Rehabilitation and Support Services

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

We aim to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities, people with mental health problems and people who have age-related disabilities. These services encompass home-based support services, residential care support services, day services and palliative care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups.

By helping to restore function and independent living the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. Effective support services make a major contribution to enabling people to live at home for longer, thereby not only improving their well-being but also reducing the burden of institutional care costs to the health system.

Output: Home-based support

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Q	94.6%	95%	Q2 2014/15
Percentage of NASC clients assessed within 6 weeks	T	95%	95%	CY 2014

Output: Palliative care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Number of Advance Care Plan conversations recorded in Collaborative Care Management System (CCMS) will increase by 20%	Q	3101	3721	Target for 14/15
Number completing at least one module of training as Level 1 practitioners each year	Q	160	200	Jul 2014 - Feb 2015
Proportion of hospice patient deaths that occur at home	Q	24%	↑	April 2014 – Feb 2015
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	1%	↓	April 2014 – Feb 2015

Output: Residential care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Total number of subsidised aged residential care bed days - Rest homes - Hospitals - Dementia - Psychogeriatric	V	981,671 318,161 556,324 94,898 12,288	Ω	12 months to Sept 2014
Proportion of aged care providers with 4 year audit certification	Q	23%	↑	Feb 2014

Module 4: Financial Performance

Financial management overview

Our financial goal is to remain financially sustainable well into the future. This is an extremely challenging goal in the current environment, and savings are required for us to remain within budget for the next four years.

Given the overall slower funding growth for the DHB sector, combined with significant cost pressures faced by the public health sector, a deliberate strategy to maintain our financial sustainability is required. We will achieve our financial goal through:

- Prioritising our work programmes to get the best health service for the people in our district and region
- A culture of financial accountability and discipline underpinned by a Business Transformation and Performance Improvement Programme to continuously identify and implement improvement initiatives
- Careful planning and implementation of affordable capital developments that enable us to continue meeting the health service delivery requirements for our district and for the national services we provide
- Implementing smarter ways of delivering quality health services more efficiently, more cost effectively and reducing waste. We will do this in partnership with our Waitemata DHB colleagues and also regionally and nationally through existing shared service agencies, such as healthAlliance.

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

- We are on target to achieve a year end surplus of $0.3M for 2014/15. To achieve the planned result for the year and maintain financial sustainability, we have continued to effectively manage Inter District Flow (IDF) revenue and expenditure, contain cost pressures across our services and successfully progress our business transformation and performance improvement initiatives. The savings target for 2014/15 of $39.5M is expected to be fully achieved, including unplanned savings that offset any that are no longer achievable
- We are providing for known IDF-related risks to cover any adverse IDF wash-ups and also continuing work to ensure we meet planned IDF volume levels and minimise this risk
- A desk-top review of asset values has been completed and this indicates a significant increase in the value of land. As a result, a full revaluation of land will be completed.

Our focus and commitment to maintaining long-term financial sustainability requires us to not simply focus on achieving breakeven results. Rather, we are being more purposeful and deliberate in planning intelligently about how we will meet the growing demand for health services and how we will efficiently utilise the human and capital resources available to us well into the future. Living within our means is no longer just an annual requirement, but a real mission core to the future sustainability of our services. On this basis, we are planning to achieve breakeven results in each of the four planning years.

We will continue to implement asset management improvement projects, including looking after our current asset base by implementing appropriate upgrades, refurbishments, replacements and maintenance programmes using our free cash flow from depreciation. We will also use our limited available cash carefully to meet new facility, clinical equipment and technology investments to support the growth and improvements in health services we provide to our population and those of other DHBs. Given the limited capital envelope for the DHB sector (and indeed for most government sectors), we will continue to work and collaborate with our regional partners to ensure that we are making the right capital investments, in the right places and at the right time.

Significant and serious steps have been taken to reduce costs at Auckland DHB over the past three years, underpinned by a comprehensive savings programme. This delivered savings of over $140M over the 2012/13 and 2013/14 financial years and we are on target to achieve a further $39.5M in 2014/15. For 2015/16, we are planning to achieve savings of $25M. As well as the savings programme, there has been a complete overhaul of the Provider arm leadership structure for the organisation in 2014, with creation of sensible, more

manageable directorates, led by clinical leaders as the single points of accountability. This is an enabler of sustainable ongoing system change required to meet health needs and live within the signalled funding path.

In 2014/15 $10m of funding was received from the Ministry of Health as a one off amount to support continued service provision of national and tertiary services while a number of actions were put in place to make these services sustainable. The funding was spent on maintaining service levels, conducting reviews and re-configuring services.

Actions either underway or completed are as follows:

- Case for additional funding for National Paediatric Cardiac Service was submitted to DHB Funding and Planning Managers and accepted for $2m funding in the 2015/16 year
- Additional funding $1.25m to pay for increase in the National Clinical Genetics Service was approved
- Additional funding in 2015/16 was approved for Paediatric Metabolic and Paediatric Rheumatology Services
- Delivery of heart and lung transplants above the historically funded level. Heart and lung transplants were not capped at the funded level in 2014/15 but all possible transplants were delivered. The $10m one-off funding contributed to supporting this. Total annual heart and lung transplant volumes were static between 2006 and 2012, averaging around 20 per year and matching the funded level. The availability of organs for transplant has been the limiting factor. Since 2013 there has been an increase in the number of organs available. In 2013 there were 28 transplants performed, in the 2014 calendar year the number rose to 34 and the forecast for 2015 is 48 transplants. A case has been prepared and submitted regarding ongoing funding for these procedures. To keep providing this level of transplants the DHB will need to increase capacity as currently tertiary cardiac surgery may need to be cancelled to accommodate this level of volume
- Tertiary service reviews have begun, focusing firstly on paediatric tertiary specialties. The purpose of the reviews is to specify clearly the types and level of services to be delivered, and ensure the services delivered match DHB funders' requirements. Output, outcome and efficiency measures will be agreed with the sector for these services as part of this process.

Key Assumptions for Financial Projections

Revenue Growth

The two major sources of revenue for Auckland DHB are Population Based Funding Formula (PBFF) revenue and IDF revenue.

Growth in PBFF revenue for 2015/16 is based on the National Health Board funding envelope advice, with an increase of $34.087M or 3.17% over the 2014/15 funding envelope (after rebasing adjustments).

Growth in IDF Inflow revenue for 2015/16 is, again, based on the National Health Board funding envelope advice and updates to this, with an increase of $22.636M or 3.22% over the 2014/15 funding envelope (after rebasing adjustments). A significant reduction in IDF revenue of $73M has been included, reflecting an agreed change in treatment of funding for laboratory and PHO services (with associated reduction in expenditure), that has been agreed with Waitemata DHB. Auckland acts as an agent for Waitemata DHB in relation to payments for these services. Other relatively minor allowances have also been made for agreed changes in service delivery or production output where appropriate since the funding advice was received.

As per the guidance from the National Health Board, we have assumed for outer years that the PBFF funding increase will be of the same nominal value as that signalled for 2014/15, i.e. $34.087M. We have assumed that IDF revenue will increase by 1.6%, which is lower than the average of the PBFF increase for our neighbouring regional DHBs. We have assumed no further service changes with respect to IDF revenue for this final version of the Annual Plan.

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

Expenditure Growth

Underlying expenditure growth of $40.7M or 2.0% above the 2014/15 forecast level is planned. However in the summary tables this is distorted by the reduction in expenditure of $73M associated with the agreed reduction in IDF revenue. The underlying cost growth is driven by demographic growth pressure on services provided for the local and regional population, cost growth to meet national services demand growth, cost growth for employment contracts (including automatic step increases), cost of capital for facility developments and general inflationary pressure on clinical and non-clinical supplies and services. Key expenditure assumptions include:

- We estimate that for 2014/15, the combined growth of both our own Auckland population and the IDF population will result in an increase in workload above 2014/15 of around 3.5% (including laboratory services transferred in-house)
- Impact on personnel costs of all settled employment agreements, automatic step increases, SMO job sizing allowances, increase in FTEs, risk provisions for expired employment contracts and of employment agreements expiring during the planning period. We estimate that the impacts of these changes, (net of savings anticipated and staff transfers) will be in the order of $25.285M or 3.0% over 2014/15 forecast
- FTE numbers for 2015/16 are planned to grow by 158 from 2014/15 budget, mainly in Allied Health staff, with the total FTEs expected to increase from 8,393 to 8,551
- Clinical supplies growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of growth in services provided by the DHB. healthAlliance Procurement and Supply chain teams and other national entities in order to realise more savings in this area
- Infrastructure cost growth (not including interest, depreciation and capital charge) in this category are based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. While these have resulted in increases we have been able to contain these costs by reductions in other costs in the same category
- The Business Transformation and Performance Improvement Programme is a key tool being used by the DHB to manage cost pressures by identifying savings to ensure the DHB lives within its means. For 2015/16, overall performance improvement savings of $25M are planned
- Funder payments to external providers are expected to increase by $13.6M (not including IDF outflows which are as advised by the Ministry of Health)
- Impact of interest income from the shared banking arrangements in place and interest expense for the debt drawn with the Crown and that transferring to the Crown from Private Bonds
- Outer Years Expenditure - as the revenue projection for outer years has largely been determined at National Health Board level, future expenditure levels have been reduced to align with funding growth levels and to ensure that breakeven is maintained. The funding gap is expected to continue to increase and this is planned to be covered by cost savings from the ongoing Business Transformation and Performance Improvement initiatives and a continued review of the services we provide and value added of these to improved patient outcomes.

Financial Risks

The achievement of $25M incremental savings from performance improvement initiatives is a challenge considering the progressive savings achieved to date. Initiatives considered to be most difficult to achieve are those involving system-wide design, review of skill mix, reconfiguring surgical services and sizing of tertiary services, teaching and training and national services to improve affordability. These initiatives will need to result in lower staffing costs, which is the most difficult area of cost to reduce.

Risk assessment of savings will be an on-going programme to ensure that where planned savings are no longer achievable, offsetting ones will have to be identified and implemented in order to achieve the planned breakeven position.

Forecast Financial Statements

In line with requirements of Section 139(2) of the Crown Entities Act 2004, we provide both the financial statements of Auckland DHB and its subsidiaries (together referred to as "Group") and Auckland DHB's interest in associates and jointly controlled entities. The Auckland DHB group consists of the parent, Auckland District Health Board and The Auckland DHB Charitable Trust (A+ Trust) Foundation (controlled by Auckland District Health Board).

The tables on the following pages provide a summary of the consolidated financial statements for the audited result for financial year 2013/14, year-end forecast for the 2014/15 financial year and financial plans for the years 2015/16 to 2018/19.

Statement of Comprehensive Income - Group

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,248,311	1,264,036	1,290,335	1,329,322	1,368,331	1,407,360
Non-Government & Crown Agency Sourced	84,223	98,087	78,203	79,376	80,567	81,775
IDFs and Inter-DHB Sourced	672,446	700,746	664,406	674,991	685,745	696,670
TOTAL FUNDING	**2,004,980**	**2,062,869**	**2,032,944**	**2,083,689**	**2,134,642**	**2,185,805**
EXPENDITURE						
Personnel Costs	808,133	831,492	857,742	874,896	892,394	910,242
Outsourced Costs	86,082	98,238	95,687	97,600	99,552	101,543
Clinical Supply Costs	230,627	233,534	239,097	242,683	246,323	250,018
Infrastructure & Non-Clinical Supplies Costs	183,751	191,825	186,980	204,549	221,723	238,492
Payments to Providers	592,284	599,199	539,844	548,582	557,459	566,475
IDF Outflows	103,840	108,552	111,229	113,008	114,816	116,653
TOTAL EXPENDITURE	**2,004,716**	**2,062,840**	**2,030,577**	**2,081,319**	**2,132,267**	**2,183,425**
NET SURPLUS (DEFICIT)	**263**	**29**	**2,367**	**2,370**	**2,375**	**2,380**
Gains/ (Losses) on Property Revaluations	37,197					
TOTAL COMPREHENSIVE INCOME	**37,460**	**29**	**2,367**	**2,370**	**2,375**	**2,380**

A commitment to financial sustainability is the basis for the planned breakeven financial performance indicated in the table above. However, the plans include savings amounting to $25M required to achieve an underlying Break-even financial result.

The DHB has a planned surplus of at least $2.37M in each of the years in the planning period. This is predicated on a $2.33m revenue payment from the Ministry of Health, with the first payment expected to be received in June 2016. Should this not proceed for any reason or not be deemed recognisable revenue in 2015/16, then the DHB planned result will be breakeven. The DHB is committed to sustainable financial performance throughout the planning period and onwards. This will require on-going ability to contain costs in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

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

Statement of Comprehensive Income - Parent

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,248,311	1,264,036	1,290,335	1,329,322	1,368,331	1,407,360
Non-Government & Crown Agency Sourced	70,215	92,143	74,832	75,938	77,060	78,198
IDFs and Inter-DHB Sourced	672,446	700,746	664,406	674,991	685,745	696,670
TOTAL FUNDING	**1,990,972**	**2,056,926**	**2,029,573**	**2,080,251**	**2,131,135**	**2,182,228**
EXPENDITURE						
Personnel Costs	803,478	831,492	857,742	874,896	892,394	910,242
Outsourced Costs	84,922	97,418	95,687	97,600	99,552	101,543
Clinical Supply Costs	228,772	233,299	239,111	242,698	246,338	250,033
Infrastructure & Non-Clinical Supplies Costs	179,667	189,313	185,428	202,966	220,107	236,846
Payments to Providers	592,284	599,199	539,844	548,582	557,459	566,475
IDF Outflows	103,840	108,552	111,229	113,008	114,816	116,653
TOTAL EXPENDITURE	**1,992,963**	**2,059,272**	**2,029,040**	**2,079,751**	**2,130,667**	**2,181,793**
NET SURPLUS (DEFICIT)	**(1,991)**	**(2,347)**	**533**	**500**	**468**	**435**
Other Comprehensive Income						
Gains/ (Losses) on Property Revaluations	37,197					
TOTAL COMPREHENSIVE INCOME	**35,206**	**(2,347)**	**533**	**500**	**468**	**435**

Capital Costs

We note that included in the infrastructure and non-clinical supplies costs are capital related costs in the form of Interest, Depreciation and Capital Charge (IDCC) which represent at least 50% of this cost category. Interest costs are driven by the applicable interest rates on the debt portfolio with the Crown ($254.5M) and private sector bonds ($50M). Depreciation reflects the size and value of our asset base and rates of annual usage applied to the asset classes, with the increase in depreciation reflecting continued investment in facilities and equipment over time and impact of asset revaluations. Capital charge reflects the Crown's return on investment in the DHB and is impacted by upward movements in asset valuations. These costs are summarised in the table below.

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
FINANCING COSTS						
Interest	16,326	16,271	13,662	13,662	13,662	13,662
Depreciation	40,333	42,186	43,650	47,124	49,134	51,392
Capital Charge	37,227	40,378	40,344	40,344	40,344	40,344
TOTAL FINANCING COSTS	**93,886**	**98,835**	**97,657**	**101,130**	**103,140**	**105,398**
% of Infrastructure & Non Clinical Supply Costs	**51%**	**52%**	**52%**	**49%**	**47%**	**44%**

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

Statement of Cashflows - Group

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Cashflow from operating activities						
Cash was provided from						
MoH and other Government/Crown	1,919,345	1,972,644	1,963,503	1,997,312	2,056,084	2,105,999
Other Income	75,220	90,225	69,441	70,483	71,540	72,613
	1,994,565	2,062,869	2,032,944	2,067,794	2,127,624	2,178,612
Cash was applied to						
Payment for Personnel	(792,888)	(831,492)	(840,587)	(874,896)	(892,394)	(910,242)
Payments for Supplies	(410,226)	(420,516)	(424,106)	(443,702)	(464,458)	(484,655)
Capital Charge Paid	(37,227)	(40,378)	(40,344)	(40,344)	(40,344)	(40,344)
Net GST Paid	572	-	-	-	-	-
Payments to Providers	(694,770)	(695,767)	(640,275)	(661,591)	(672,275)	(683,129)
	(1,934,539)	(1,988,152)	(1,945,313)	(2,020,533)	(2,069,471)	(2,118,371)
Net Cash Flow from Operating Activities	**60,026**	**74,718**	**87,631**	**47,261**	**58,152**	**60,241**
Investing Activities						
Cash was provided from						
Interest Received	7,297	7,862	8,762	8,893	9,027	9,162
Proceeds from Sale of Fixed Assets	-	-	-	-	-	-
Decrease / (Increase) in investments	(22,799)	-	(4,133)	-	-	-
	(15,502)	7,862	4,629	8,893	9,027	9,162
Cash was applied to						
Capital Expenditure	(29,633)	(72,090)	(90,861)	(48,489)	(52,354)	(52,354)
Net Cash (Outflow) from Investing Activities	**(45,135)**	**(64,228)**	**(86,232)**	**(39,596)**	**(43,327)**	**(43,192)**
Financing Activities						
Proceeds from Capital Raised/(Repaid) from	-	-	-	-	-	-
Proceeds from Loans Raised	-	-	-	-	-	-
Interest Paid	(16,209)	(16,271)	(13,662)	(13,662)	(13,662)	(13,662)
Net Cash (Outflow) from Financing Activities	**(16,209)**	**(16,271)**	**(13,662)**	**(13,662)**	**(13,662)**	**(13,662)**
Net Cash Inflow/(Outflow)	**(1,318)**	**(5,781)**	**(12,263)**	**(5,997)**	**1,163**	**3,387**
Cash & cash equivalents at start of the year	**97,118**	**95,800**	**90,018**	**77,755**	**71,758**	**72,921**
Cash & cash equivalents at end of the year	**95,800**	**90,018**	**77,755**	**71,758**	**72,921**	**76,307**

Cash flow forecasts reflect the result of maintaining breakeven operating results. Breakeven operating results give rise to cash surpluses, essentially from the depreciation stream, which can be used to fund the capital projects approved by the Auckland DHB Board. The capital plan includes significant investments in replacing, maintaining, upgrading our current asset bases, investing in technology assets and also in assets required to meet growth, quality improvements and compliance. We currently have borrowing facilities with the Ministry of Health (MoH) of $254.5m, all of which have been drawn. We also have $50.0M in Bonds on issue until

September 2015. The bonds will be refinanced by the Crown on maturity.

Statement of Cashflows - Parent

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Cashflow from operating activities						
Cash was provided from						
MoH and other Government/Crown	1,919,345	1,972,644	1,963,503	1,997,312	2,056,084	2,105,999
Other Income	62,546	86,223	67,506	68,515	69,533	70,566
	1,981,890	2,058,867	2,031,009	2,065,826	2,125,616	2,176,564
Cash was applied to						
Payment for Personnel	(788,233)	(831,492)	(840,587)	(874,896)	(892,394)	(910,242)
Payments for Supplies	(403,117)	(416,370)	(422,554)	(441,083)	(461,801)	(481,958)
Capital Charge Paid	(37,227)	(40,378)	(40,344)	(40,344)	(40,344)	(40,344)
Net GST Paid	572	-	-	-	-	-
Payments to Providers	(694,770)	(695,767)	(640,275)	(661,591)	(672,275)	(683,129)
	(1,922,775)	(1,984,006)	(1,943,761)	(2,017,915)	(2,066,815)	(2,115,673)
Net Cash Flow from Operating Activities	**59,115**	**74,862**	**87,248**	**47,912**	**58,802**	**60,892**
Investing Activities						
Cash was provided from						
Interest Received	6,405	7,031	7,326	8,043	8,177	8,312
Proceeds from Sale of Fixed Assets	-	-	-	-	-	-
Decrease / (Increase) in investments	(23,032)	-	(10,607)	-	-	-
	(16,627)	7,031	(3,281)	8,043	8,177	8,312
Cash was applied to						
Capital Expenditure	(29,633)	(72,090)	(90,861)	(48,489)	(52,354)	(52,354)
Net Cash (Outflow) from Investing Activities	**(46,260)**	**(65,059)**	**(94,142)**	**(40,446)**	**(44,177)**	**(44,042)**
Financing Activities						
Proceeds from Capital Raised/(Repaid) from	-	-	-	-	-	-
Proceeds from Loans Raised	-	-	-	-	-	-
Interest Paid	(16,209)	(16,271)	(13,662)	(13,662)	(13,662)	(13,662)
Net Cash (Outflow) from Financing Activities	**(16,209)**	**(16,271)**	**(13,662)**	**(13,662)**	**(13,662)**	**(13,662)**
Net Cash Inflow/(Outflow)	**(3,354)**	**(6,468)**	**(20,556)**	**(6,196)**	**962**	**3,187**
Cash & cash equivalents at start of the year	**94,733**	**91,379**	**84,911**	**64,355**	**58,158**	**59,121**
Cash & cash equivalents at end of the year	**91,379**	**84,911**	**64,355**	**58,158**	**59,121**	**62,308**

Statement of Financial Position - Group

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
ASSETS						
CURRENT ASSETS						
Cash and cash equivalents	95,799	90,018	77,755	71,758	72,921	76,307
Trust/special funds	11,966	7,700	7,700	7,700	7,700	7,700
Debtors and other receivables	49,302	47,797	35,097	53,020	57,887	60,806
Prepayments	1,060	1,166	1,166	1,166	1,166	1,166
Inventories	12,211	13,168	12,723	12,723	12,723	12,723
	170,339	159,849	134,441	146,367	152,397	158,702
NON CURRENT ASSETS						
Trust/special funds	10,783	14,548	14,548	10,783	10,783	10,783
Property, Plant and Equipment	898,464	919,064	963,783	898,164	884,748	872,498
Intangible Assets	307	92	7,856	2,204	2,107	2,010
Derivatives financial instruments	722	-	-	-	-	-
Investments in joint ventures & associates	51,997	54,850	61,483	75,289	75,289	75,289
	962,273	988,554	1,047,670	986,440	972,927	960,580
TOTAL ASSETS	**1,132,612**	**1,148,403**	**1,182,111**	**1,132,807**	**1,125,324**	**1,119,283**
LIABILITIES						
CURRENT LIABILITIES						
Trade and other payables	104,663	114,271	138,457	99,381	90,019	85,296
Employee benefits	167,820	172,521	182,554	169,584	169,112	165,411
Interest-bearing loans and borrowings	82,670	52,780	1,442	31,814	31,793	31,793
	355,153	339,572	322,453	300,779	290,924	282,499
NON-CURRENT LIABILITIES						
Employee benefits	33,941	34,115	32,575	32,575	32,575	32,575
Interest-bearing loans and borrowings	224,500	254,500	304,500	274,500	274,500	274,500
Patient and restricted trust funds	-	1,169	1,169	1,169	1,169	1,169
Derivatives financial instruments	-	4,246	3,693	3,142	2,591	2,040
	258,441	294,030	341,937	311,386	310,835	310,284
TOTAL LIABILITIES	**613,594**	**633,602**	**664,390**	**612,165**	**601,759**	**592,783**
EQUITY						
Public Equity	576,798	576,798	576,798	576,798	576,798	576,798
Accumulated deficit	(464,409)	(464,380)	(462,014)	(459,644)	(457,268)	(454,889)
Other reserves	406,629	402,383	402,936	403,488	404,035	404,589
Trust/special funds						
TOTAL EQUITY	**519,018**	**514,801**	**517,720**	**520,642**	**523,565**	**526,499**
NET ASSETS	**1,132,612**	**1,148,403**	**1,182,111**	**1,132,807**	**1,125,324**	**1,119,283**

A strong asset base is indicated, with total assets planned to maintain a value greater than $960M throughout the planning period. Full asset revaluations were completed in 2013 and the next full revaluation will be

completed in 2016. A desk top analysis of asset values completed recently indicates a significant increase in the value of land and a full revaluation will be completed to inform the 2014/15 year end financial position.

The Cashflow Hedge reserve relates to the hedge accounting treatment of the settlement amount on the Bond Forward Rate Agreement (Bond FRA) that was entered into by the DHB in August 2012. The Bond FRA was settled on 15 April 2015 and the amount is amortised over eight years to 2023.

Statement of Financial Position - Parent

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
ASSETS						
CURRENT ASSETS						
Cash and cash equivalents	91,379	84,911	64,355	58,158	59,121	62,307
Trust/special funds	-	-	-	-	-	-
Debtors and other receivables	47,794	45,935	33,397	51,170	55,387	57,406
Prepayments	1,060	1,166	1,166	1,166	1,166	1,166
Inventories	12,211	13,168	12,723	12,723	12,723	12,723
	152,445	145,181	111,641	123,217	128,397	133,602
NON CURRENT ASSETS						
Trust/special funds	-	-	5,748	1,783	1,583	983
Property, Plant and Equipment	897,562	918,163	962,881	897,263	883,847	871,597
Intangible Assets	307	92	7,856	2,204	2,107	2,010
Derivatives financial instruments	722	-	-	-	-	-
Investments in joint ventures & associates	51,997	54,850	61,483	75,289	75,289	75,289
	950,588	973,105	1,037,968	976,539	962,826	949,879
TOTAL ASSETS	**1,103,033**	**1,118,286**	**1,149,609**	**1,099,756**	**1,091,223**	**1,083,482**
LIABILITIES						
CURRENT LIABILITIES						
Trade and other payables	100,007	111,453	135,088	97,326	88,817	84,333
Employee benefits	167,820	172,521	182,554	169,584	169,112	165,411
Interest-bearing loans and borrowings	82,670	52,780	1,442	31,814	31,793	31,793
	350,498	336,754	319,084	298,725	289,721	281,537
NON-CURRENT LIABILITIES						
Employee benefits	33,941	34,115	32,575	32,575	32,575	32,575
Interest-bearing loans and borrowings	224,500	254,500	304,500	274,500	274,500	274,500
Patient and restricted trust funds	-	1,169	1,169	1,169	1,169	1,169
Derivatives financial instruments	-	4,246	3,693	3,142	2,591	2,040
	258,441	294,030	341,937	311,386	310,835	310,284
TOTAL LIABILITIES	**608,939**	**630,784**	**661,021**	**610,111**	**600,556**	**591,821**
EQUITY						
Public Equity	576,798	576,798	576,798	576,798	576,798	576,798
Accumulated deficit	(489,332)	(491,679)	(491,146)	(490,640)	(490,167)	(489,726)
Other reserves	406,629	402,383	402,936	403,488	404,035	404,589
Trust/special funds	-	-	-	-	-	-
TOTAL EQUITY	**494,095**	**487,502**	**488,588**	**489,646**	**490,667**	**491,661**
NET ASSETS	**1,103,033**	**1,118,286**	**1,149,609**	**1,099,756**	**1,091,223**	**1,083,482**

Disposal of Land

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

Statement of Movement in Equity – Group

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Balance at 1 July	481,558	519,018	514,801	517,721	520,643	523,566
Comprehensive Income/ (Expense)						
Surplus/Deficit for the Year	263	29	2,367	2,370	2,375	2,380
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	37,197					
Cashflow Hedge Reserve		(4,246)	553	552	548	554
Total Comprehensive Income	**37,460**	**(4,217)**	**2,920**	**2,921**	**2,923**	**2,934**
Owner Transactions						
Capital Contributions from the Crown	-	-	-	-	-	-
Balance at 30 June	**519,018**	**514,801**	**517,721**	**520,642**	**523,566**	**526,500**

The shareholder's equity position improved in 2013/14 due to the increase in the value of land. The reduction in the 2014/15 year reflects the impact of the Bond FRA hedge accounting.

Statement of Movement in Equity - Parent

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Balance at 1 July	458,889	494,095	487,503	488,589	489,646	490,667
Comprehensive Income/ (Expense)	-	-	-	-	-	-
Surplus/Deficit for the Year	(1,991)	(2,347)	533	505	474	440
Other Comprehensive Income	-	-	-	-	-	-
Gains/(Losses) on Property Revaluations	37,197	-	-	-	-	-
Cashflow Hedge Reserve	-	(4,246)	553	552	548	554
Total Comprehensive Income	**35,206**	**(6,593)**	**1,086**	**1,057**	**1,021**	**994**
Owner Transactions						
Capital Contributions from the Crown	-	-	-	-	-	-
Balance at 30 June	**494,095**	**487,503**	**488,589**	**489,646**	**490,667**	**491,662**

Additional Information

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

Funder Arm Financial Performance

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Government & Crown Agency Sourced	1,167,686	1,179,569	1,198,542	1,236,153	1,273,764	1,311,374
Non-Government & Crown Agency Sourced	104	-	-	-	-	-
IDFs and Inter-DHB Sourced	657,392	685,733	649,258	659,646	670,201	680,924
Total Revenue	**1,825,182**	**1,865,302**	**1,847,800**	**1,895,799**	**1,943,964**	**1,992,298**
Expenditure						
Payment to Provider	1,104,963	1,142,026	1,183,067	1,220,192	1,257,317	1,294,442
Payment to Governance	5,639	10,975	11,331	11,687	12,042	12,398
	1,110,602	**1,153,001**	**1,194,398**	**1,231,878**	**1,269,359**	**1,306,840**
NGO Expenditure						
Personal Health	418,845	444,444	355,979	361,041	366,166	371,357
Mental Health	35,719	30,016	39,502	40,293	41,098	41,920
DSS	135,528	123,055	141,064	143,885	146,762	149,698
Public Health	1,034	866	2,053	2,094	2,136	2,179
Maori Health	1,158	818	1,245	1,270	1,295	1,321
	592,284	**599,199**	**539,844**	**548,583**	**557,458**	**566,475**
IDF Outflows	103,840	108,552	111,229	113,008	114,816	116,653
	696,124	**707,751**	**651,072**	**661,591**	**672,275**	**683,129**
Total Expenditure	**1,806,726**	**1,860,752**	**1,845,470**	**1,893,469**	**1,941,634**	**1,989,968**
Surplus / (Deficit)	**18,457**	**4,550**	**2,330**	**2,330**	**2,330**	**2,330**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**18,457**	**4,550**	**2,330**	**2,330**	**2,330**	**2,330**

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

We note that as part of the collaboration between Auckland and Waitemata DHBs, the two DHBs have moved to a joint Planning and Funding division, with Waitemata DHB employing planning and funding staff on behalf of the two DHBs. However, funder arm financial plans and performance for Auckland DHB will continue to be reported through Auckland DHB financial accounts and statement of service performance.

Provider Arm Financial Performance

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Income	1,104,963	1,142,026	1,183,067	1,220,192	1,257,317	1,294,442
MoH Base via Funder	50,310	52,545	57,598	58,462	59,339	60,229
MoH Direct	129,144	144,994	127,545	129,428	131,339	133,278
Other						
Total Income	**1,284,416**	**1,339,565**	**1,368,211**	**1,408,082**	**1,447,995**	**1,487,949**
Expenditure						
Personnel	801,788	826,813	854,514	871,604	889,036	906,817
Outsourced Services	84,766	88,657	85,981	87,701	89,455	91,244
Clinical Supplies	230,627	233,312	238,978	242,563	246,201	249,894
Infrastructure & non clinical supplies	174,011	185,069	181,995	199,258	216,130	232,606
Other	10,598	9,416	6,707	6,917	7,127	7,358
Total Expenditure	**1,301,789**	**1,343,266**	**1,368,176**	**1,408,042**	**1,447,950**	**1,487,899**
Surplus / (Deficit)	**(17,373)**	**(3,701)**	**35**	**40**	**46**	**50**
Other Comprehensive Income						
Gains/ (Losses) on Property Revaluations	**37,197**					
Total Comprehensive Income	**19,824**	**(3,701)**	**35**	**40**	**46**	**50**

The Provider Arm is expected to move to a breakeven regime as the Funder has illustrated in the plan. This requires significant savings to be generated in the Provider Arm. Detail of these will be provided in the final Annual Plan.

Governance and Funding Administration Arm Financial Performance

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Revenue from Funder Arm	**5,639**	10,975	11,331	11,687	12,042	12,398
Revenue Other	**344**	28	-	-	-	-
Total Income	**5,983**	**11,004**	**11,331**	**11,687**	**12,042**	**12,398**
Expenditure	**6,804**	11,823	11,331	11,687	12,042	12,398
Surplus / (Deficit)	**(821)**	**(820)**	**(0)**	**(0)**	**(0)**	**0**
Total Comprehensive Income	**(821)**	**(820)**	**(0)**	**(0)**	**(0)**	**0**

The Governance and Funding Administration arm continues to perform within the funding allocated, with a breakeven forecast in 2014/15 and the continuation of breakeven results planned throughout the planning period.

Capital Expenditure

The ten year Capital Intentions for the DHB, signalling the priority projects for the short to medium term was completed in January. This was prepared from the perspective of affordability of the Capital programme, with no expectation of additional funding from the Crown, other than the depreciation free cashflow. This information was provided to the National Health Board. These capital intentions are included in the 2015/16 Annual Plan/Statement of Intent Capital Intentions Plan. The Capital Plan summarised below reflects planned baseline capital projects and strategic capital projects that have been approved. Unapproved strategic projects are not included in the summary.

Summary Capital Expenditure

	2013/14 Audited $'000	2014/15 Forecast $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000
Funding Sources						
Free cashflow from depreciation	**40,333**	42,186	43,650	47,124	49,134	51,392
External funding	**-**	-	-	-	-	-
Cash Reserves	**97,118**	95,800	65,931	14,622	9,824	4,639
Total Funding	**137,451**	**137,986**	**109,581**	**61,745**	**62,430**	**61,513**
Baseline Capital Expenditure						
Land	**832**	5,614	-			
Buildings and Plant	**815**	23,927	16,520	18,117	19,561	19,561
Clinical Equipment	**21,327**	21,255	39,855	20,718	22,708	22,708
Other Equipment	**1,348**	3,480	4,930	2,325	2,511	2,511
Information Technology (hardware)	**808**	5,691	10,287	5,815	6,374	6,374
Intangible Assets (software)	**229**	692	776	750	750	750
Motor Vehicles	**277**	400	405	450	450	450
Total Baseline Capital Expenditure	**25,636**	**61,059**	**72,773**	**48,175**	**52,354**	**52,354**
Strategic Investments						
Land	**-**	-	-			
Buildings and Plant	**1,552**	5,676	19,088	314	-	-
Clinical Equipment	**2,445**	5,355	-	-	-	-
Information Technology	-	-	-	-	-	-
Intangible Assets (software)	-	-	3,133	-	-	-
Total Strategic Capital Expenditure	**3,997**	**11,031**	**22,221**	**314**		
Total Capital Payments	**29,633**	**72,090**	**94,994**	**48,489**	**52,354**	**52,354**

Banking Facilities and Covenants

Term Debt Facilities

We have term debt facilities of $254.5M with the Ministry of Health which are fully drawn and a public Bond issue of $50M repayable in September 2015. This is the last remaining private sector finance facility in place for Auckland DHB. An application for refinance debt appropriation was submitted to the Ministry of Health in 2014 and this was approved. We are awaiting documentation of the loan to enable the funds to transfer for paying out the Bonds when they mature in September 2015.

Shared Commercial Banking Services

Health Benefits Limited (now Health Partnership Ltd) undertook a project on behalf of all DHBs to identify a preferred commercial banking services provider for the DHB sector. Westpac was the preferred supplier of banking services from the Request for Proposal process. All DHBs have accepted Westpac as the banking services provider for the sector. DHBs are no longer required to maintain separate stand-by facilities for working capital.

Banking Covenants

Auckland DHB is subject to a Negative Pledge Deed with parties to the Deed being the Ministry of Health (as successors to the Crown Health Financing Agency), MBIA New York as insurer on behalf of the Bond holder, and the following banks; ANZ, BNZ, Westpac and CBA/ASB.

MODULE 5: Stewardship

Auckland DHB must put high level strategic planning into action in order to effectively and efficiently deliver the priority actions described in modules 1 and 2. The DHB needs a supportive infrastructure to achieve this. Some of the key enablers that help us manage our business are covered below.

Managing our business

In order to manage our business effectively and efficiently to deliver on the priorities and activities described in modules 1 and 2, we must translate our high level strategic planning into action in an organisational sense within the DHB and have in place supportive infrastructure requirements to achieve this. We must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We must also ensure that every public dollar spent is spent wisely with the overall intention of improving, promoting and protecting the health of our population.

Organisational performance management

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

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

Risk management

We continue to monitor our risk management practices to ensure we were meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. We have developed a joint risk management framework with Waitemata DHB. This enables both DHBs to be consistent in the approach to managing and controlling risks particularly where risks are similar and also in consideration of risks that may arise from the collaboration work underway. We will continue to develop innovative ways to support the service delivery changes needed. Improving the effectiveness and efficiency of 'in-house' tasks frees resources for health care delivery.

Auckland DHB is significantly impacted by the size of its tertiary and national services' income and the actions of other DHBs relating to this. Mitigation of risk will require effective regional and national decision making.

Effective Procurement

We will actively work with the Ministry of Business, Innovation and Employment (MBIE) to comply with the government rules for sourcing to undertake procurement efficiently and according to best practice standards. A Strategic Procurement Outlook will be published through MBIE and we will provide an Annual Procurement Plan. This will support achievement of viable and sustainable health services delivered by primary care and other nongovernment organisations, key partners in helping us provide quality healthcare for our population.

Asset management

Asset management plan development

We have an asset management plan that helps inform the capital requirements of the DHB in the short to long term. The Asset Management Plan outlines our current physical asset base used in delivering health services, the condition of the assets, refurbishment, upgrades and replacement requirements over the long term. The plan also outlines the key strategic projects planned for the medium term.

Overall, the plan supports investment decisions by providing asset replacement profiles, which facilitate management and ongoing maintenance of the current asset base as well as informing future asset requirements to continue to meet the growing demand for health services provided by our DHB. The plan was last fully updated in 2011 including high level projections of how future health service demand would impact on Auckland DHB's asset base. Since then, the capital intentions underlying the plan have simply been updated annually to reflect known changes in asset states and short-term capital intentions. The Plan is currently being updated with a 2014 version planned to be complete by the end of this financial year.

The capital intentions signalled in our 2015/16 annual plan are informed by the longer-term asset renewal and growth requirements identified in our Asset Management Plan and through consultation with our services. We have provided the Auckland DHB capital intentions to the National Health Board for the next ten years (February 2015) and this will continue to be updated as new priorities emerge. These mostly reflect our short to medium term capital priorities as well as the long-term projects outlined in the Asset Management Plan. We have also provided information on our future capital intentions to the Northern Region Agency to help inform capital needs for the Northern region.

We are working collaboratively with Waitemata DHB on implementing best practice capital processes and business case development principles across our DHBs. In 2014, we combined the Facilities and Development function across both DHBs. Both DHBs are following the same capital related policies and procedures and the investment manual that incorporates some of the NZ Treasury Better Business Case development principles. We continue to work on improving our investment decisions to ensure that we are investing wisely and making the most of our limited capital funding to support the capital and infrastructure requirements of the health services we provide.

We continue to work towards incorporating principles of best practice asset management planning into our business-as-usual processes. During 2014, we completed a self-assessment of Asset Management Maturity in response to a request from the NHB. Auckland DHB is one of nine DHBs for which independent assessment of this was completed. From this process we identified a number of asset management improvement projects which we will be undertaking. These are briefly noted below and will be outlined in the updated Asset Management Plan.

Our updated Asset Management Plan will reflect asset management improvement initiatives we are planning and working on and progress on these. Areas under consideration include:

- **Addressing Asset Data Integrity and Quality Issues:** Improving the quality of our asset data and related processes will better inform our capital needs and decisions
- **Clinical Equipment Asset Verification and Cataloguing:** We are planning to review and verify our clinical equipment with a view to creating a catalogue for high value clinical equipment assets with a value of $10,000 or more
- **Buildings Condition Assessments:** We have completed the high level condition assessments for all buildings owned by us as required by the Ministry's annual Asset Stock-take. The Asset Management Plan includes scheduled renewal of all major building and plant items (e.g. roofs, boiler and chillers) and the condition of these assets is regularly monitored by our Facilities Management. This is done by planned preventative maintenance checks scheduled in the BEIMS maintenance system, real-time monitoring of critical plant on the Building Management System and condition assessments undertaken by Facilities Management staff as major assets approach their scheduled renewal dates

- **Seismic Compliance Assessment:** We have been active in improving seismic compliance since 1999 when our Seismic Risk Management Plan (SRMP) was first prepared. Since then, a number of buildings have been exited, strengthened or demolished. In 2012, an update of the SRMP was undertaken to reflect new standards and engineering techniques. IEP analysis was undertaken for all major pre-1995 buildings. Out of this, only one additional structure (apart from those already identified) was found to be in need of strengthening and this is currently underway
- **Site Master Planning**: Work is ongoing around key strategic capital projects and timing of these in the medium to long term, including consideration of financing options for these. Clinical Services Planning information will be critical in determining the staging of all major facilities redevelopments to be included in the updated Site Master Plan and Asset Management Plan

Capital Investment

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

Auckland DHB has put considerable effort into establishing a new clinically led organisational structure that identified single points of accountability for all aspects of managing service provision. Work is progressing on clinical services planning to model the demand growth for services, review the way we are providing services and work on new models of care that are more cost and/or clinically effective and sustainable operationally and financially in the long run. This work has and will continue to inform the strategic capital priorities for the DHB for the next ten years and beyond. Work completed so far, including that from previous site master planning and asset management planning identified the following key Capital intentions for the next ten years, (including placeholder projects). Business cases are being developed for some of these to inform the scope, scale and costs. These have been included in the Capital Intentions template submitted to the NHB together with this Annual Plan. Projects that require Ministry of Health or Ministerial approval will follow the national capital investment approval process and those requiring DHB Board approval only will follow the regional capital approval processes.

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

Capital Intentions in $'000s	Estimated Total Capital Cost	Project Timeframes	Status
ACH Integrated Cancer Centre	17,400	2016 -2018	Business case under development
Dialysis Unit Rebuild	25,425	2016 -2018	Business case under development
Expansion of Endoscopy Suite at ACH and Greenlane	15,000	2017 - 2019	Business case under development
Accident & Emergency Department Expansion	25,000	2017 -2020	Business case under development
Inpatient Bed Growth	30,000	2021 - 2022	Strategic placeholder
New Radiotherapy Capacity	22,501	2019 - 2020	Strategic placeholder
Greenlane Clinical Centre- new Car Park Building	10,000	2024 - 2025	Strategic placeholder
ACH additional car parking capacity	10,000	2019-2020	Strategic placeholder
Mental Health 30 new acute & extended care beds for growth	14,850	2021 - 2022	Strategic placeholder
Northern Region Electronic Health Record (NEHR)	TBA	2017 -2018	Implementation Planning work underway to inform business case
Balance of Funding Available*2	**170,176**		

Emergency planning

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

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

Building Capability

National and regional programmes

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

- Agreement of appropriate standards and the consistency of care delivery across our region
- Development of new models of care to achieve the best clinical outcomes and efficient use of the region's health resources
- The use of information technology to enable integrated and patient- and whānau-determined health; crossing organisational boundaries and extending along the continuum of care.

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

- Implementation of shared services programmes e.g. Linen and laundry and food services
- Supporting health promotion agency campaigns e.g. national health target activities, supporting women to reduce alcohol consumption during pregnancy, alcohol screening and brief intervention
- Continued development of infection control programmes and infection management systems
- Supporting the implementation of national IT initiatives, such as patient and provider portals and the roll out of electronic medicines reconciliation (eMR)
- Supporting National Health Committee strategies to develop improved models of care
- Supporting PHARMAC procurement programmes e.g. for hospital medical devices.

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

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

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

Building IT capacity

The Northern Regional Information Strategy (RIS 2010-20) and the Northern Region Information Systems Implementation Plan were developed in 2009 to set the direction for information management, systems and services in the Northern Region for the period 2010 – 2020. The strategy aligns with the National IT Plan, and is a key enabler for us to achieve our clinical and business objectives. At the midway point of the RIS 2010-20 timeframe, we reflected on our progress towards achieving our RIS2010-20 for more streamlined, patient-centred care, enabled by information technology. We are not making progress quickly enough; it is time to change our approach.

In 2014/15, ADHB led a regional project to select a vendor partner for an implementation planning study to replace various patient administration systems across the region. Key stakeholders agreed that the scope of the project should be extended to include an integrated electronic health record solution to enable transformational change in the way we deliver care across the health systems to our population. A vendor partner was selected, and in 2015/16, we will complete an implementation planning study to inform our business case for a regional patient administration system and integrated, electronic health record to accelerate progress towards achieving our RIS 2010-20 vision.

Fundamental to the achievement of our clinical and business objectives is the performance of our shared services support agency, healthAlliance NZ Ltd. In 2015/16, the Northern Region CIO Group comprising representatives from each DHB and healthAlliance (hA) will continue to support hA by:

- Ensuring the Northern Region DHBs/hA IS Service Catalogue reflects the requirements of the Northern Region DHBs in IS shared services
- Monitoring the performance of IS shared services in line with regional priorities and requirements
- Prioritising the regional ICT programme of work, ensuring that resilience and security risks are appropriately managed
- Providing strategic IS direction for the region
- Prioritising national, regional and local capital IS/business transformation (non-ICT) projects
- Monitoring the performance of key projects.

Historic underinvestment in information communications technology (ICT) infrastructure has resulted in an inherent service continuity risk for IS services and a bow wave of infrastructure upgrade and system resilience requirements in the Northern Region. The Northern Region DHBs began to address this in 2013/14, and this has continued in subsequent years. In 2015/16, infrastructure investment will be made in G2012 Microsoft licence compliance, including update of servers to Microsoft Windows 2008, extended support for Microsoft 2003, and compliance with the Department of Internal Affairs mandate for the use of supported software. Clinical and business system upgrades will continue as part of an ongoing programme to improve system resilience and security. The regional plan also supports a five-yearly IT replacement cycle to ensure that hardware assets are fit for purpose.

In addition to the above priorities, Auckland DHB will undertake the following activities with respect to key national, regional and local projects to ensure regional alignment, and to improve clinical safety and effectiveness:

- eMedicines Reconciliation (national) – implementation of eMedicines Reconciliation (eMR) functionality and clinical processes to improve clinical safety
- ePrescribing & Administration (national) – implementation of ePrescribing & Administration (ePA) functionality and clinical processes in two hospital wards to improve clinical safety
- eDischarge (national) – implementation of the new, national standard for eDischarge across hospital services to improve the quality of discharge information from secondary care to primary care providers and patients
- Surgical Site Infection Surveillance (SSIS) (national) – implementation of an infection prevention and control system to improve clinical safety and provide SSIS data to the national database

- Shared Care Planning (national) - continued implementation of the shared care planning tool to support the management of complex, long term conditions and the localities joint initiative with the PHOs
- National Patient Flow (national) – implementation of system and process changes to enable compliance with mandatory reporting in 2016/17
- Faster Cancer Treatment (national) – implementation of phase 2 compliance reporting
- eReferrals (regional) - implementation of phase 3; intra and inter DHB e-Referrals functionality across hospital services to improve referral processes within and across the Auckland metro DHBs
- RIS/PACS (regional) – upgrade of core infrastructure and establishment of a regional platform
- Clinical Pathways (regional) - continued implementation of dynamic clinical pathways, and static pathway development
- Laboratory eOrders (regional) – implementation of eOrders functionality and clinical processes for laboratory orders in secondary care to improve clinical safety
- CSSD (regional) – replacement of the TDocs CSSD system with the Nexus system, including the implementation of single instrument tracking for surgical instruments
- Enterprise Content Management (regional) – system implementation to support business requirements for the management of corporate records, and Public Records Act compliance
- Mobility Adoption (regional) - development of a regional mobility strategy to guide our investment decisions and installation of wifi infrastructure to provide coverage across key clinical and patient areas
- Patient Portal (local) – implementation of a secondary care portal to enable patients to view and interact with their clinical record.

Quality and safety

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

In 2015/16, we want to move from a focus on incremental improvement to transformational change programmes. We are looking to embed quality improvement throughout the organisation, at a service level. We are committed to improving patient safety and the experience of our patients, working with our regional and sub-regional partners as well as the Health Quality and Safety Commission. We aim to build staff capability and capacity through a range of training programmes while strengthening our clinical governance structures and processes across the organisation. Specific actions are included in Module 2 'Patient Experience' and 'Quality'.

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

Workforce

Managing our workforce within fiscal restraints

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

Strengthening our workforce capacity

We will work with our regional partners to develop and implement regional workforce strategies with a focus on government priority areas and targets, and internally to strengthen our workforce in relation to Culture, Capability, Capacity and Change Leadership. The DHB supports the regional approach to implementing nurse specialist palliative care educator and support roles, expanding the role of specialist nurses to perform colonoscopies, addressing key workforce requirements with regard to the medical physicist workforce and providing access to community-based placements.

We will also work with the Regional Training Hub Director to develop and deliver a workforce plan as part of the 2015/16 Regional Service Plan. The workforce plan will outline regional actions and key milestones.

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

Our current workforce

FTE	Other	Pacific	Māori	TOTAL
Administration	928	119	70	1,116
Allied Health	661	56	59	776
Nursing	2,932	346	96	3,374
Other support	276	82	16	373
RMO	682	12	7	700
SMO	769	6	9	783
Technical	886	88	19	994
Total	**7,132**	**709**	**275**	**8,116**

Headcount	Other	Pacific	Māori	TOTAL
Administration	1,137	138	84	1,359
Allied Health	897	62	68	1,027
Nursing	3,719	390	121	4,230
Other support	322	89	19	430
RMO	558	11	9	578
SMO	957	7	10	974
Technical	1,121	105	20	1,246
Total	**8,711**	**802**	**331**	**9,844**

Headcount excludes casual staff. Sourced from Leader, accurate as at 1 February 2015

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

Strengthening our workforce culture

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

We will focus on:

- Attraction and retention by developing healthy workplaces activity, promoting cultural diversity and supporting, developing and rolling out programmes to embed our new values

- Capacity and capability - ensuring Auckland DHB staff have the capacity and capability to achieve the DHB's strategic aims and support the cultural programmes for Māori, Pacific and Asian workforces that improve access/engagement and health outcomes
- Values - developing a programme to embed organisational awareness of the new values and articulating what standards and behaviours are expected
- Leadership and management - embedding and improving the leadership culture at Auckland DHB whilst supporting the new operating model roll out

Safe and competent workforce

We will continue the development of processes to comply with the Vulnerable Children's Act.

We will review our recruitment policies and processes and implement amendments to comply with the safety checks to reduce the risk of harm to children. As required, we will introduce three yearly reassessments for existing employees within two years. The safety checking information about people employed or engaged by Auckland DHB in work that involves regular or overnight contact with children will be available for provision to the Director-General of Health. Our Abuse and Neglect policy and guidelines are available on our internet site.

Organisational health

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

Our Good Employer policy makes clear that we will:

- Recognise the aims, aspirations and employment requirements of Māori people
- Recognise the aims, aspirations, cultural differences and employment requirements of Māori and Pacific Island people and people from other ethnic or minority groups
- Provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- Ensure that employees maintain proper standards of integrity and conduct in accordance with our values
- Provide a healthy and safe workplace
- Provide recruitment, selection and induction processes that recognise the employment requirements of women, men and persons with disabilities
- Provide opportunities for individual employee development and career advancement.

Reporting and consultation

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

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

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

Ability to enter into service agreements

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

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

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

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

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.

Service coverage and service change

Type of service change	Area impacted by service change	Description of service change
Level, location and configuration of services	Maternity services	Changes and/or enhancements to maternity care under the guidance of the ADHB/WDHB women's health collaboration including to maternity facilities in the district, as determined by both the Auckland and Waitemata Boards in October 15
Change in model of service delivery	Cervical screening	Subject to decisions taken by the Ministry of Health regarding devolving funding, potential changes to independent service provider model of service delivery across the district – likely to commence during 2015/16.
Change in model of service delivery	Mental Health Services, PHOs and NGO	Increased interface and integration with primary care, Whānau ora and schools – may increase primary care access to support hours
Change in model of service delivery	Mental Health Services and NGO – Eating Disorders Service	Revised funding model will result in adjustments to the model of care
Configuration of services	Mental Health Services	Full implementation of Mother and Baby respite beds and support hours
Change in model of service delivery	Health of Older People	Work is underway to achieve an aligned Home and Community Support Services (HCSS) model at Auckland and Waitemata DHBs; this will result in changes to existing HCSS models at both DHBs. A RFP for this service will be undertaken in 2015/16
Change in service provider/s and configuration of services	Oral health – relief of pain services	Reviewing current service configuration to ensure geographically equitable access to services. Likely to tender for new service provider/s at end of current contract term.
Change in model of service delivery and possible change in service provider	Pregnancy and Parenting Education service	New or renewed provider/s and/or provider model to be implemented following RFP during 2015/16
Change in model of service delivery	Sexual Health services regionally	Implementation of new model of care with service specifications established for the regional sexual health services, including priority population groups

Type of service change	Area impacted by service change	Description of service change
		and increased access to primary care options for all populations
Change in model of service delivery	Outpatient services	Services are expected to reduce high volumes of face-to-face outpatient activity and replace this with alternative methods of delivery such as Virtual, Telemedicine and Nurse-led provision
Level and configuration of services	Tertiary services	Auckland DHB will be reviewing the specification and costing of tertiary services. Findings may impact on the configuration and scope of some services for the northern region.

MODULE 7: Performance Measures

Monitoring framework performance measures

Performance measure	2015/16 National performance expectation/target		DHB target	
PP6 Improving the health status of people with severe mental illness through improved access	**Age 0-19 years**	Māori	5.5%	
		Total	3.0%	
	Age 20-64 years	Māori	12.0%	
		Total	4.0%	
	Age 65+ years	Total Maori	4.0% 4.25%	
PP7: Improving mental health services using transition (discharge) planning and employment	Long-term clients	Provide a report as specified		
	Child and youth with a transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan	95%	
PP8: Shorter waits for non-urgent mental health and addiction services for 0 to 19-year-olds	Mental Health Provider Arm			
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19 years	80%	95%	80%	95%
	Addictions (Provider Arm and NGO)				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19 years	80%	95%	80%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1		0.90	
	Ratio year 2		0.85	
PP11: Children caries-free at five years of age	Ratio year 1		69%	
	Ratio year 2		70%	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		87%	
	% year 2		87%	
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		85%	
	0-4 years - % year 2		95%	
	Children aged 0-12 years not examined % year 1		7%	
	Children aged 0-12 years not examined % year 2		6%	
PP18: Improving community support to maintain the independence of older people	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan		95%	
PP20: Improved management for long-term conditions (CVD, diabetes and Stroke)				
Focus area 1: Long-term conditions	Report on delivery of the actions and milestones identified in the Annual Plan			
Focus area 2: Diabetes Management (HbA1c) Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 Annual Plan Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control		Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	
Focus area 3: Acute coronary syndrome services	70% of high-risk patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0')		70%	

Performance measure	2015/16 National performance expectation/target	DHB target
	Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	95%
	Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge	95%
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI	
Focus area 4: Stroke Services	6% of potentially eligible stroke patients thrombolysed	8%
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
PP21: Immunisation coverage (previous health target)	IPIF Healthy Start - % of two-year-olds fully immunised	95%
	Percentage of five-year-olds fully immunised	90% by end 2015/16; 95% by end 2016/17
	Percentage of eligible girls who have received dose three of HPV vaccine	65% (for dose 3)
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan	
PP25: Prime Minister's youth mental health project	Quarterly narrative and quantitative reports on the following initiatives: • Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. • Initiative 3: Youth Primary Mental Health • Initiative 5: Improve the responsiveness of primary care to youth	
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/ongoing	
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan	
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic are 55% lower than the average over the last 3 years	1.4 per 100,000
PP29: Improving waiting times for diagnostic services	Coronary angiography: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	CT and MRI: a) 95% of accepted referrals for CT scans b) 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	95% 85%

Performance measure	2015/16 National performance expectation/target		DHB target
	Diagnostic colonoscopy: a) 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) b) 60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)		75% 65%
	Surveillance colonoscopy: 60% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		65%
PP30: Faster cancer treatment	Part A: Faster cancer treatment – 31 day indicator		<10% of the records submitted by the DHB are declined
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy		All patients ready for treatment receive treatment within four weeks from the decision to treat
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4 years		To be advised
	Age 45-64 years		
	Age 0-74 years		
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives		
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage		
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement		21 per 10,000
	Cataract procedures		27 per 10,000
	Cardiac surgery		6.5 per 10,000
	Percutaneous revascularisation		12.5 per 10,000
	Coronary angiography services		34.7 per 10,000
SI5: Delivery of Whânau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been		
SI6: IPIF Healthy Adult - Cervical Screening	Enrolled women 25 – 69 years who have received a cervical smear in the past three years		80%
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.59 days, which represents the 75th centile of national performance	1.59 days
	Acute LOS	Maintenance of, or improvement on 2013 baseline performance	2.63 days
OS8: Reducing Acute Readmissions to Hospital	Total population		Improve against baseline
	Individuals aged 75+ years		Improve against baseline

Performance measure	2015/16 National performance expectation/target	DHB target
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections **Focus area 1: Improving the quality of identity data**	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	Greater than 2% and less than or equal to 4%
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%
	Invalid NHI data updates	Pending
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% to less than 99.5%	Greater than or equal to 97% and less than 99.5
	National collections file load success Greater than or equal to 98% to less than 99.5%	Greater than or equal to 98% and less than 99.5%
	Standard vs. edited descriptors Greater than or equal to 75% to less than 90%	Greater than or equal to 75% and less than 90%
	NNPAC timeliness Greater than or equal to 95% to less than 98%	Greater than or equal to 95% and less than 98%
Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD data quality	Routine audits undertaken with appropriate actions where required
Output 1: Mental health output Delivery Against Plan	Volume del*ivery for specialist Mental Health and Addiction services is within:* a) 5% variance (+/-) of planned volumes for services measured by FTE, b) 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV4: Improving patient experience	No performance target set	

MODULE 8: Appendices

Appendix 1: DHB Board and management

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

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

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

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

Appendix 2: statement of accounting policies for the year ending 30 June 2016

The following 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 as a first time adopter of the new Public Benefit Entity accounting standards for financial reporting, budgeting and forecasting will be provided in the 2014/15 Annual Report that will be published on the website: www.adhb.govt.nz/publications.

REPORTING ENTITY

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

Auckland DHB'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.

Auckland DHB and the group is a Public Benefit Entity (PBE) for financial reporting purposes.

The consolidated financial statements include the DHB and its subsidiaries and interest in associates and jointly controlled entities.

BASIS OF PREPARATION

Statement of compliance

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

The financial statements are prepared in accordance with Tier 1 PBE accounting standards.

The financial statements comply with PBE accounting standards.

The 2014/15 financial statements will be the first financial statements presented in accordance with the new PBE accounting standards.

Measurement base

The financial statements are prepared on a historical cost basis, except for investment properties, land and buildings classified as property, plant and equipment, derivative financial instruments and available-for-sale investments, which have been measured at fair value.

Presentation currency and rounding

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

Standards issued that are not yet effective and not early adopted

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on and after 1 Jul 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting statements was updated to incorporate requirements and guidance for the not-for-profit sector. These updated statements apply to PBEs with reporting periods beginning on or after 1 April 2015. The DHB will apply these updated standards in preparing its 30 June 2016 financial statements. The DHB expects there will be minimal or no change in applying these updated accounting standards.

BASIS FOR CONSOLIDATION

Subsidiaries

Subsidiaries are entities controlled by Auckland DHB. Control exists when Auckland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust and has control. Consistent accounting policies have been used for both Auckland DHB and the Charitable Trust.

Subsidiaries are consolidated from the date on which control is obtained by the group and cease to be consolidated from the date on which control is transferred out of the group.

In preparing the consolidated financial statements, all intercompany balances and transactions, revenue and expenses and profit and losses resulting from intra - group transactions have been eliminated in full.

Joint Ventures

A joint venture is an entity over whose activities Auckland DHB has joint control, established by contractual agreement. The consolidated financial statements include Auckland DHB's joint interest in the joint venture, using the equity method, from the date that joint control commences until the date that joint control ceases. There are no differences in accounting policies between the parent and joint venture entities.

Treaty Relationship Company Limited is a joint venture company (50% owned) with Te Runanga O Ngati Whatua. Originally created as a vehicle through which to channel joint health related activities, it has not undertaken any business for some years and as at the date of this report work is underway to wind up the company.

HealthAlliance N.Z. Limited is a joint venture company with Health Partnership Ltd (previously Health Benefits Limited) and Auckland, 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.

NZ Health Innovation Hub Management Limited.

The four largest District Health Boards (Counties Manukau, Auckland, Waitemata and Canterbury) have established a national Health Innovation Hub. The Hub engages with the DHBs, clinicians and Industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding in the limited partnership and the general partner, NZ Health Innovation Hub Management Limited, which was incorporated on 26 June 2012.

Associates

Associates are those entities in which Auckland DHB has the power to exert significant influence, but not control, over the financial and operating policies. Auckland DHB holds a 33% shareholding in Northern Regional Alliance Limited (NRA).

Associates are accounted for at the original cost of the investment plus Auckland DHB's share of the change in the net assets of associates on an equity accounted basis, from the date that the power to exert significant influence commences until the date that the power to exert significant influence ceases. When Auckland DHB's share of losses exceeds its interest in an associate, Auckland DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Auckland DHB has incurred legal or constructive obligations or made payments on behalf of an associate. There are no differences in accounting policies between the parent and associate entities.

Northern Regional Alliance Limited is an associate with Auckland, Counties-Manukau and Waitemata DHBs. It exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland Region DHBs and to provide a shared services agency to the Northern Region DHBs in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

Revenue

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

MOH revenue

The DHB is primarily funded through revenue received from the MoH.

This funding is restricted in its use for the purpose of the DHB meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

ACC contracted revenue

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

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the Auckland DHB region is domiciled outside of Auckland. The MoH credits Auckland DHB with a monthly amount based on estimated patient treatment for non Auckland residents within Auckland. An annual wash up occurs (in agreed areas) at year end to reflect the actual non Auckland patients treated at Auckland DHB.

Donated services

Certain operations of the DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance sheet.

Donations and bequests

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

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

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

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

Leases

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

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

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

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

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

Receivables
Short term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments

Bank term deposits
Investments in bank term deposits are initially measured at the amount invested.

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

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. Fair value movements are recognised in the surplus or deficit.

The fair value of forward exchange contracts is their quoted market price at the balance sheet date, being the present value of the quoted forward price. The fair value of interest rate swaps is the estimated amount that Auckland DHB would receive or pay to terminate the swaps at balance date taking into account the current interest rates and the current credit worthiness of the counter-party.

Auckland DHB classifies the value of derivatives into their current and non-current portions, based on their expected maturity dates.

DHB Bond FRA

Auckland DHB uses Bond Forward Rate Agreements (Bond FRAs) to hedge interest rate repricing risk inherent in the maturity profile of its underlying Debt portfolio. Bond FRAs are initially recognised at fair value on the date the contract is entered into, and are subsequently re-measured at the fair value at each balance date. Where considered appropriate, Auckland DHB applies hedge accounting to achieve the intention of Bond FRAs entered into.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential.

Inventories acquired through non –exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

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

- land;
- buildings (including fitouts and underground infrastructure);
- leasehold Improvements
- plant , equipment and vehicles
- Work in progress

Owned Assets

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

Revaluations

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

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

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

Additions

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

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at fair value as at the date of acquisition.

Disposals

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

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

• Buildings (including components)	1-89 years	1.12%-100%
• Plant, equipment and vehicles	2-20 years	5.00%-50%
• Leasehold improvements	4-8 years	12.5%-25%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

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

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

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

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

Amortisation

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

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

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

Indefinite life intangible assets are not amortised.

FPSC rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Partnership Limited (NZHPL, previously Health Benefits Ltd - HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

Cash generating assets

Auckland DHB has no cash-generating assets.

Non-cash generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value.

Borrowings

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

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

Employee entitlements

Short-term employee entitlements

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

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

A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

Long-term entitlements

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

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

Presentation of employee entitlements

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

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

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

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced. Future operating costs are not provided for.

ACC Accredited Employers Programme

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

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

Equity

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

- Contributed capital;
- accumulated surplus/(deficit);
- Reserves - property revaluation and cashflow hedge; and

- trust funds.

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

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

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

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

Budget figures
The budget figures are derived from the Statement of Intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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

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

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

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Glossary

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

LMC	Lead Maternity Carer
LTC	Long Term Conditions
Mana whenua	People who have authority over the land
Mataawaka	Māori living in the Auckland region whose ancestral links lie outside of the Tāmaki Makaurau region
MHP	Māori Health Plan
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCSP	National Cervical Screening Programme
NIR	National Immunisation Register
NRA	Northern Region Alliance (North and Northern Region DHB support Agency)
NSH	North Shore Hospital
OIS	Outreach Immunisation Service
ORL	Otorhinolaryngology (ear, nose, and throat)
Pai ora	Healthy futures
PAM	Potentially Avoidable Hospital Admissions
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care
Q1, Q2, Q3, Q4	Quarters 1-4, i.e. by 30 September, 31 December, 31 March or 30 June
RACIP	Residential Aged Care Integration Programme
Rangatahi	Youth
RFP	Request for Proposal
SIA	Services To Improve Access
SME	Self Management Education
Tāngata Whai i te Ora	People seeking wellness, mental health service users
Tamariki ora	Child services
Te Pou Matakana	North Island Whānau Ora Commissioning Agency
Te Runanga o Ngāti Whātua	Ngāti Whātua Tribal Council
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention
WCTO	Well Child/Tamariki Ora
Whānau	Extended family
Whānau hui	Meeting with extended family or family group
Whānau Ora	Families supported to achieve their maximum health and wellbeing
WTK	Waitakere Hospital
YTD	Year-to-date

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai