Auckland District Health Board

Annual Plan 2011-12

Incorporating the Statement of Intent for 2011-2014

30 June 2011

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Status of this Document

30 June as final

Approvals

Auckland DHB	CPHAC recommends Board approve the review copy for NHB 16 March 2011
Auckland DHB	Approved 18 May 2011
Minister of Health	Approved 18 July 2011

Auckland DHB planning documents, once approved, are available on the website www.adhb.govt.nz (under News and Publications)

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Office of Hon Tony Ryall

Minister of Health
Minister of State Services

18 JUL 2011

Dr Lester Levy
Chair
Auckland District Health Board
PO Box 92 189
Victoria Street West
AUCKLAND 1142

Dear Dr Levy

Auckland District Health Board 2011/12 Annual Plan

This letter is to advise you I have approved Auckland District Health Board's (DHB) 2011/12 Annual Plan.

This year has seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your cooperation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery.

I am pleased to see your DHB is planning to breakeven for the three planning years and that your plan notes a focus on identifying actions to ensure you continue to live within your means.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience. It is important that you collaborate with your regional DHB colleagues to develop this integration effectively.

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

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan including better links with your regional colleagues, more tangible actions and deliverables to show how you will achieve the objectives of your business cases. The Government expects significant progress to be made in implementing the business cases and deliverables this year and we will be watching developments with interest.

Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board's work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

I expect to see delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan and look forward to seeing greater ongoing support for the work of Health Benefits Limited in developing shared back office functions where appropriate. I also thank you for your continued commitment to work with the Health Quality and Safety Commission.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see detail of how you are planning to deliver health services for older people in your Annual Plan. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHBs continued application of the comprehensive clinical assessment tool (interRAI) currently being rolled out nationally. Better articulation of how improvements are being sought in this priority area will be expected from all DHBs in next years Annual Plan.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded as a way of working within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government's Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the growing expectations of the public.

I appreciate Auckland DHB's efforts to deliver on the Health Targets and your progress in delivering on these. It is good to see that you have identified more specific actions within your Annual Plan that you will take to ensure you achieve your planned performance on the six Health Targets. I expect continued progress in this area, particularly towards the targets for Shorter Stays in Emergency Departments and Better Diabetes and Cardiovascular Services.

Mental Health Ringfence

I am approving your plan subject to an expectation that your DHB works closely with the Ministry of Health, to agree and ensure appropriate use of currently unallocated mental health ringfence funding in order to achieve improvements in mental health for your population.

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. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework and you will need to advise the National Health Board of any proposals that may require my approval.

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

I acknowledge that the impacts for DHBs of the earthquakes in Christchurch over the last year are difficult to determine and that these have not been taken into account in producing Annual Plans. The impacts of these events are ongoing for the health sector and will need to be managed beyond what is included in your Annual Plan.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely

Ryall

Hon Tony Ryall
Minister of Health

Module 1: Introduction

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

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

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

Foreword

This plan has a strong drive to improve performance – improvements in patients' experience, measurable improvements in health outcomes for Aucklanders, especially those who experience the poorest of health, and a more efficient health care system. Clinical staff will lead the changes required and our performance improvement framework – Healthcare Excellence – will be the method we use to achieve the priorities of Auckland District Health Board.

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

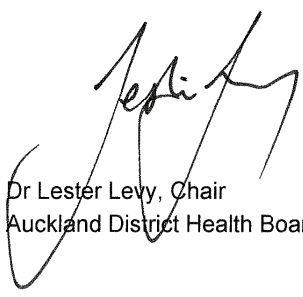
- a greater focus and determination to achieve our goals
- authentic leadership and highly disciplined management
- strengthened collaboration within and outside of the organisation (particularly with Waitemata District Health Board and primary care)
- enhanced accountability at all levels in the organisation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

The Auckland DHB Board has identified ten priorities for clinical and executive management attention over the 2011-12 year. The Board's priorities act in harmony with the national targets and together form the compelling sense of priority for the organisation. The Auckland DHB Board is committed to:

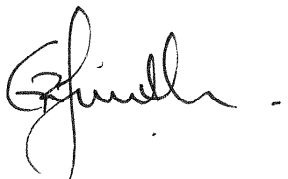
- ensuring the 6 national health targets are met or exceeded as soon as possible (no later than December 2011)
- clinical excellence coupled with patient service
- regional collaboration and integration
- clinical leadership
- proactive management of emerging issues
- innovative models of care
- ensuring value for money in all we do
- addressing the needs of priority populations (children, Maori, Pacific, disabled, older people, "new" New Zealanders)
- financial discipline.

The plan that follows sets out the actions to deliver these priorities. Our detailed actions will be measured to show evidence of:

- increased patient safety
- better quality of care
- economic sustainability
- improved health status of our population
- an engaged workforce.



Dr Lester Levy, Chair
Auckland District Health Board



Garry Smith, Chief Executive
Auckland District Health Board

This Annual Plan 2011–12 (incorporating Statement of Intent 2011–2014 material) is signed for and on behalf of:

Auckland District Health Board

28/06/2011

Dr Lester Levy
Chair

Date

24/6/11.

Dr Chris Chambers
Board member

Date

Our Treaty of Waitangi partners
Te Runanga o Ngati Whatua

ONZM. JP. 23.6.2011

R Naida Glavish JP
Chair, Te Runanga o Ngati Whatua

Date

And signed on behalf of
The Crown

Hon Tony Ryall
Minister of Health

Date

1.1 Summary of Key Deliverables for 2011–12

Auckland DHB's focus for 2011-12 will deliver the following:

1.0 Shorter Stays in Emergency Departments

95% of patients will be admitted, discharged or transferred from our adults and children's emergency departments within 6 hrs. The primary areas of focus for improvement are reducing demand through primary care initiatives, reducing the time to be seen in the emergency department, improving flow by more effective discharge management e.g. nurse facilitated discharging, rapid rounds, releasing time to care and engaging the whole organisation in the initiative.

2.0 Improved Access to Elective Surgery

We will deliver 11,950 elective surgical discharges for the Auckland DHB population. We will also achieve the target of nobody waiting longer then six months. The primary improvement initiatives to support achievement include: the new Greenlane Surgical Centre enabling greater separation of elective services, the Productive Operating Room, empowering and enabling clinicians to be innovate in respect of timely access to the first specialist assessment (FSA) e.g. GP access to community diagnostics, and innovative approaches to the pre-surgical assessment pathway.

3.0 Shorter Waits for Cancer treatment- Radiation Therapy

We will ensure 100% of patients ready for treatment in categories A, B, and C waiting less than 4 weeks between a decision to treat and the start of radiation treatment.

4.0 Increased Immunisation

We will achieve a regional immunisation target of 95% of all two year olds fully immunised by July 2012. To achieve this will require a significant increase in Maori immunisation rates which will be delivered through coordinating initiatives between health and other sectors as well as through participation in Whanau Ora.

5.0 Better Help for Smokers to Quit

By July 2012, 95% of hospitalised smokers will be provided with advice and help to quit smoking. We will implement an electronic system so services can monitor their own progress. Improvements will be achieved via a review of staff training on the ABC (ask, brief, cessation) of smoking cessation and quit card provision. There is also a requirement for primary health to take strong action on smoking. Practices will ensure that the national target is achieved i.e. 90% of patients attending primary care will be provided with advice to help quit smoking.

6.0 Better Management of Diabetes and Cardiovascular Disease

We will achieve the health targets by participating in a newly formed regional clinical network across primary and secondary care, support GP practice systems to enable complete capture of

data and improve diabetes management (including patient self-management) and access to timely retinal screening.

7.0 Clinical Leadership

We will actively participate in the 'In Good Hands' measurement and evaluation process around clinical leadership aiming for the top 10% of DHB performance. The primary areas of focus will be engagement in Healthcare Excellence, reassertion of clinical leadership across the Healthcare Service Group model at all 4 levels of management, and we will provide a comprehensive leadership development programme.

8.0 Services Closer to Home

There are a number of activities operating in the current landscape that need to be brought together to ensure that the DHBs are able to deliver better sooner and more convenient healthcare for the populations that they serve.

The Northern Regional Health Plan has now been approved and implementation will commence in the 2011-12 year, through the DHB and Better Sooner More Convenient Business Case partners' strategies and initiatives outlined in our Annual Plan. The Regional Plan provides a focus on a number of whole of system improvements that are important for all DHBs in the future.

There are three Better Sooner More Convenient (BSMC) Business Cases (Greater Auckland Integrated Health Network, National Hauora Coalition, and Alliance Health +) operating across metro Auckland, along with a number of Integrated Family Health Centre developments. These all need to be aligned and coordinated to ensure that benefits for patients are maximised, duplication is avoided, and that services are integrated and sustainable. In future, the range of regional primary care projects, such as the implementation of primary-secondary care clinical pathways, will also need to be linked into a cohesive and regionally consistent service framework. The Better Sooner More Convenient strategies are congruent with the DHB's 'Living Within Our Means' commitment. New and ongoing initiatives are expected to endorse and augment this commitment.

The ongoing implementation of Better Sooner More Convenient strategies and initiatives (as outlined in our Annual Plan and as approved in the Northern Regional Health Plan for commencing in 2011-12) is resourced at 2010-11 spend plus growth in line with Funding Envelope expectations.

At a local DHB level, we are taking a leadership role with the development of locality planning based on the new local government boundaries. Using an intersectoral approach, we will create clinically-led local networks that will facilitate an integrated approach to service delivery at the local level. These networks will become the glue that links primary care clinicians and secondary clinicians, and DHBs and BSMC business case partners together to achieve a common set of shared objectives and goals. Through a locality-based planning model we will partner with local communities and providers to identify local health need, develop local health improvement plans and deliver a better patient experience. We intend to break down historical boundaries by putting people in the centre and using real time data to understand the problems. From there we can create future models of care that better suit the needs of the patients and communities.

The Auckland metro DHBs are implementing a number of projects to deliver better, sooner, more convenient services to individuals and communities. These projects include performing minor surgery (like the removal of minor skin cancers) in the community using accredited primary care providers, improving GP access to radiology diagnostic services, developing and implementing clinical pathways across primary and secondary care, and increasing community-based options for acute care – for some groups avoiding the need to go to hospital. More accessible and integrated after hours primary care services will be available through the implementation of an Auckland Regional After-Hours Network.

'Mergent Healthcare'[1] is a developing concept that will provide integration across a number of key areas. Mergent Healthcare will aid delivery of;

- Better Sooner More Convenient Business Cases
- Integrated Family Health Centre Development
- National Targets
- Integration and shifting of services
- Workforce planning
- National Networks
- Development of new models of care

9.0 Health of Older People

We will integrate and streamline health services for older people, improve access to existing specialist inpatient dementia and delirium services. We will provide flexible packages of care, increased appropriate home-based support and ensure quality improvement in residential care drawing on client feedback. Together with primary care, we will look at innovative solutions to acute afterhours care for the older person.

10.0 Children and Young People

Improved oral health of children will be achieved through 8 new or refurbished school dental clinics, two additional mobile clinics; improved access for preschool children; enhanced oral health education, and a push to get early enrolment in dental care for Maori and Pacific populations.

We are working to ensure that all children in the Auckland DHB area get the best possible start. The new Well Child framework will broaden the scope of services to mothers, babies and pre-schoolers and 80% of all children will receive a B4 School check and access necessary interventions. More year 9 high school children will be offered Headss assessments to identify unmet health needs and we will work with the Ministry of Education to identify and address health need in students who have been suspended or stood down from school.

We will continue to engage and provide leadership regionally and nationally to ensure equitable provision of services for children.

[1] 'Mergent' healthcare is a new term that extends the concept of integrated care and describes an increasing blurring of the boundaries between traditional silos of health planning and delivery

11.0 Regionalisation through Collaboration

A regional plan has been developed that covers the four northern district health boards. The region has approved $1.2m to advance this regional work programme. The plan progresses work under three area of focus: first do no harm, life and years, and the informed patient. 'First do no harm' commits to reducing pressure injuries and falls causing harm by 20%. The IHI Global Trigger tool will measure overall safety performance and DHBs will share successful improvements across the region.

'Life and years' focuses on Cardiovascular disease, Diabetes, Health of Older People and Cancer as key health improvement targets, drawing on a whole of system, cross regional approach. There will also be a regional approach to Advance Care Planning, a workstream to improve patient and family experience, ensuring the right amount and kinds of care for all patients. Advance Care Planning helps patients to express their wishes about future health care and ensures that consent is respected if the patient becomes incapable of participating in treatment decisions.

Regionalisation will also reduce back-office costs through standardisation and consolidation of regional systems and processes. The regional entity healthAlliance NZ Ltd now manages many administrative activities previously managed by each health board.

Waitemata DHB and Auckland DHB have a shared Chair and Maori board membership, which will achieve better service planning and health delivery for people in these areas. The merge of primary care Planning and Funding Teams will increase consistency of relationships and primary care management across the two DHBs. We will continue to look for opportunities for collaboration at all levels of the organisation.

12.0 Reduced inequities

Maori

We have initiatives designed to actively address inequities evident in Maori health status. These range from community-based initiatives through to getting the health system to respond better to Maori patients and whanau. We will implement the Toi Oranga whanau ora school-based pilot, we will invest in, and actively recruit, to grow the Auckland DHB Maori health workforce, and we will make sure that each Healthcare Service Group is well prepared to respond to Maori health needs.

Pacific

Active collaboration with Pacific communities is essential to improving Pacific health outcomes. We will continue to support Healthy Village Action Zones to engage Pacific communities through the Pacific churches. Our particular focus is to enhance health service access and responsiveness for Pacific families within primary care. The management of long term conditions is a priority as is coordinating activities across the health system to improve the Pacific patient journey. Through each Health Service Group we will challenge ourselves to think, adopt and generate better ways of learning and working to improve health equity for Pacific people.

13.0 Disability

A major audit on the accessibility of Auckland DHB services has been completed from the perspectives of disabled people. Recommendations from this work will be prioritised and

implemented during the year. There will also be improved opportunities for disabled people to enter the health workforce.

14.0 Healthcare Excellence

The culture of our organisation needs to stay focused on patient safety, open disclosure, and timely and empathetic communication. We will show respect for patients and families at all times. Our clinical leaders and managers will effect changes needed to achieve that. We will improve our complaints management and establish: a bereavement service, an Online Community and a cohort of Consumer Representatives.

New models of care are needed as well as improvements to some of our hospital processes. We have committed to increasing the number of wards introducing improvements: children's and adult's services, operating rooms, cancer, emergency, general medicine, mental health and cardiothoracic services. A clinical network within the Northern Regional Cancer Network will form and implement tumour stream models. This same focus will be applied to medical oncology.

Our Rehabilitation Services will have a new design based on the principle of responsiveness to patients. We will deliver pulmonary rehabilitation closer to where patients live and improve the outcomes for people with Chronic Obstructive Pulmonary Disease.

We will participate in national workforce initiatives including the Registered Nurse First Surgical Assistant pilot, the Diabetes Nurse prescribing role and we will implement the Auckland Regional Training Hub. Workforce development for Maori and Pacific will be expanded via the Rangatahi programme, Cadetships and Scholarships, and through Nursing, Midwifery and Career Pathways. Clinicians and managers will be helped to make good decisions by improvements to our knowledge base and our systems that measure performance and demonstrate accountability.

We will develop new mental health services for vulnerable groups including young people, older adults and Maori. We will increase awareness of mental health services for high risk minority groups, including Muslims, lesbian, gay, bi-sexual and transgender people and Pacific people. We will increase our responsiveness to those with a coexisting problem (mental health and addiction), and we will scope plans for a low secure rehabilitation service for people with high and complex needs.

We use Healthcare Excellence criteria to improve our performance. Tikanga and Treaty of Waitangi principles will be integrated into the measurement and subsequent development of this framework and the actions that arise.

15.0 Living within our means

We will deliver a breakeven budget for 2011-12. The key focus is implementing rigorous discipline around risk areas e.g. elective service delivery, acute volume growth, Inter District Flow variances, community pharmacy, people costs, delivering quality and productivity improvement, leveraging national procurement benefits, and focused funder cost management. The significant pressure on cost growth, arising from increased service delivery requirements and the expectations of the labour market means our drive to identify and implement these new ways of working throughout the organisation is an imperative.

1.2 Context

Te Tiriti o Waitangi Statement

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

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

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

Whanau Ora
Auckland DHB works in partnership with Iwi to achieve a Whanau Ora approach to regional health services and whanau empowerment.

Principles in action

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

Safeguard Maori cultural concepts, values and practices	Commitment to the Maori Health Strategy, He Korowai Oranga and other national policy. Use the national Inequalities Framework, the health inequalities impact assessment tool and the national Prioritisation Framework prioritising whanau ora.

1.2.1 Health sector context

The New Zealand Public Health and Disability Act 2000 established 21 District Health Boards throughout New Zealand with the role and function to provide, or fund the provision of, health and disability services in their district. DHBs are charged with:

- improving, promoting, and protecting the health of communities
- integrating health services, especially primary and secondary care services
- promoting effective care or support of those in need of personal health services or disability support

As well as identifying and providing for the health needs of their district, DHBs are required to prepare a plan for each financial year. This plans shows how Auckland DHB will contribute to the effective and efficient delivery of health services that meet local, regional, and national needs.

The Auckland District Health Board (Auckland DHB) is a major funder and provider of health care services. The organisation funds and provides community based and secondary services to central Auckland, tertiary services to the Auckland region and tertiary services nationally. Auckland DHB will improve the health of the Auckland city population by focusing on the factors that most influence health and reduce health inequalities between groups.

The annual planning process includes a Statement of Intent which shows how the DHB intends to address local health needs via the organisation's statement of forecast service performance for the year ending 30 June 2012, including two outyears. The Statement of Intent within this document is prepared in terms of section 139 of the Crown Entities Act 2004 and sections 39 and 42 of the New Zealand Public Health and Disability Act Amendment Act, 2010.

Our Statement of Intent covers subsidiaries over which the Auckland DHB has a joint controlling interest with other DHBs. Auckland DHB has a one-third share in Auckland Regional RMO Services Ltd (previously the Northern Clinical Training Network) and this organisation produces its own Statement of Intent. Auckland DHB Charitable Trust (A+ Trust) is 100% owned by Auckland DHB. The Northern DHBs Support Agency (NDSA) develops its own Statement of Intent.

The Statement of Forecast Service Performance presents outputs under 4 output classes, measures and annual targets. Prior data of actual performance is the baseline for future targets. The Auckland DHB performance story in this Plan is consistent with Government priorities and the Minister of Health's expectations. The Auditor General will audit the accuracy and reasonableness of our achievements against these measures when they are presented in our year-end Annual Report.

Structure of this annual plan

Component of each doc	Covers	Includes
Annual Plan	How we operationalise and monitor our objectives across 3 high level goals of the Auckland DHB and the Northern Regional Health Plan	*New and priority activities for the 2011-12 year as well as approved service changes (Module 3)*
Statement of Forecast Service Performance in the Statement of Intent	The performance story for DHB i.e. the intervention logic used to deliver and monitor activity across four output classes	*Discrete number of cornerstone measures which include business as usual activities. This gives a balanced indication of the range of services provided (Module 4)*

Annual Plan

Statement of Intent

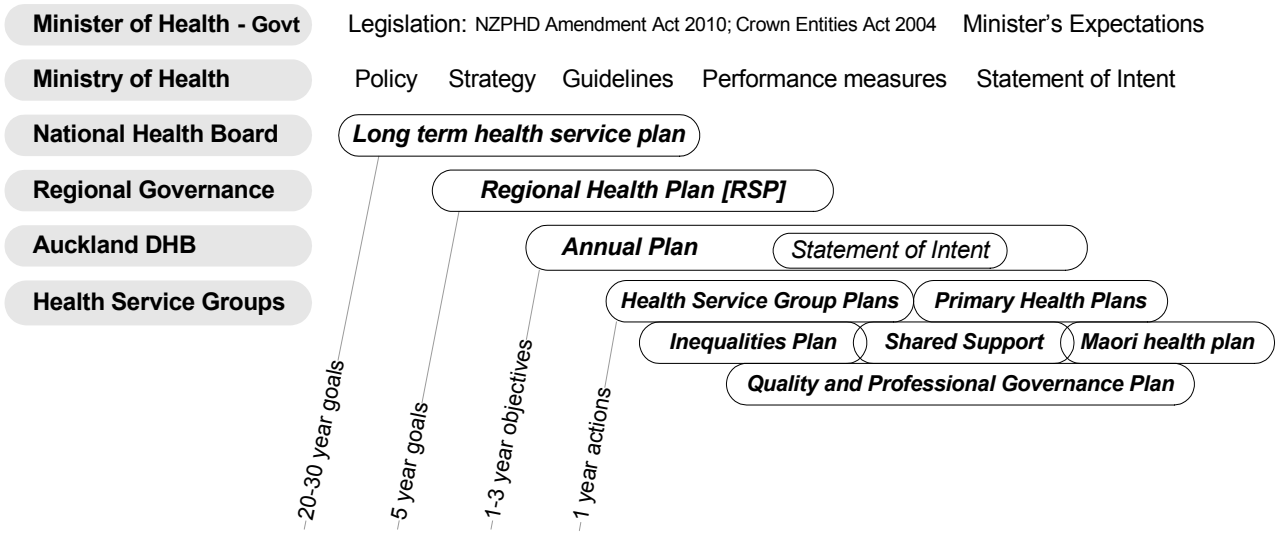
	Goal 1: Lift the health of people in ADHB	**Goal 2: Performance improvement**	**Goal 3: Live within our means**
Output class 1: Prevention	e.g. Tobacco cessation Immunisation	Joint sector work Whanau Ora	Best use of resources Cooperative agreements
Output class 2: Early detection & treatment	Oral health Diabetes get checked	More services in the community	Best use of resource Cooperative agreements
Output class 3: Intensive assessment & treatment	Mental health services Hospital-based medical care	Elective services Hospital productivity Workforce - development	Best use of resources Cooperative agreements
Output class 4: Rehabilitation & support	Home-based care for older people Respite care Rehabilitation	Quality standards Auditing Cultural supports	Best use of resources Cooperative agreements

Hierarchy of plans within the health sector

The diagram that follows shows where this Annual Plan (incorporating our Statement of Intent) sits in the hierarchy of the health sector accountability framework. Of immediate impact on the Annual Plan for the 2011-12 year is the Northern Region Health Plan which sets the longer term priorities for the four DHBs in the northern region. From 2011-12 onwards, Auckland DHB will align our annual priorities to the wider regional goals. This regional work replaces any previous Strategic Planning at the district level. These changes are brought about by amendments under the NZPHD Amendment Act 2010.

The actions in this document meet national and Government priorities for the health sector. The Minister of Health's 'Letter of Expectations' released in February 2011 specifies the priorities for the 2011-12 year. National health targets help focus the efforts of all DHBs and make more rapid progress against key national priorities. The six National Health Targets are clearly identified in this plan (Module 3) and also contribute to output class target tables in the Forecast Statement of Service Performance (module 4).

Hierarchy of national, regional and local plans



In 2011-12 we aim to be more connected to the Whanau Ora initiatives supported by Government. $134.3 million of funding is available over 4 years via Whanau Ora with the goal of positive whanau development. This funding will enable Te Puni Kokiri, the Ministry of Social Development and the Ministry of Health to integrate existing contracts into joint-agency funding arrangements. Auckland DHB will contribute a health perspective within the Regional Inter-Sectoral Whanau Ora collaborative. We are also working with other sectors on the Tamaki Transformation Project.

1.2.2 Population and health profile

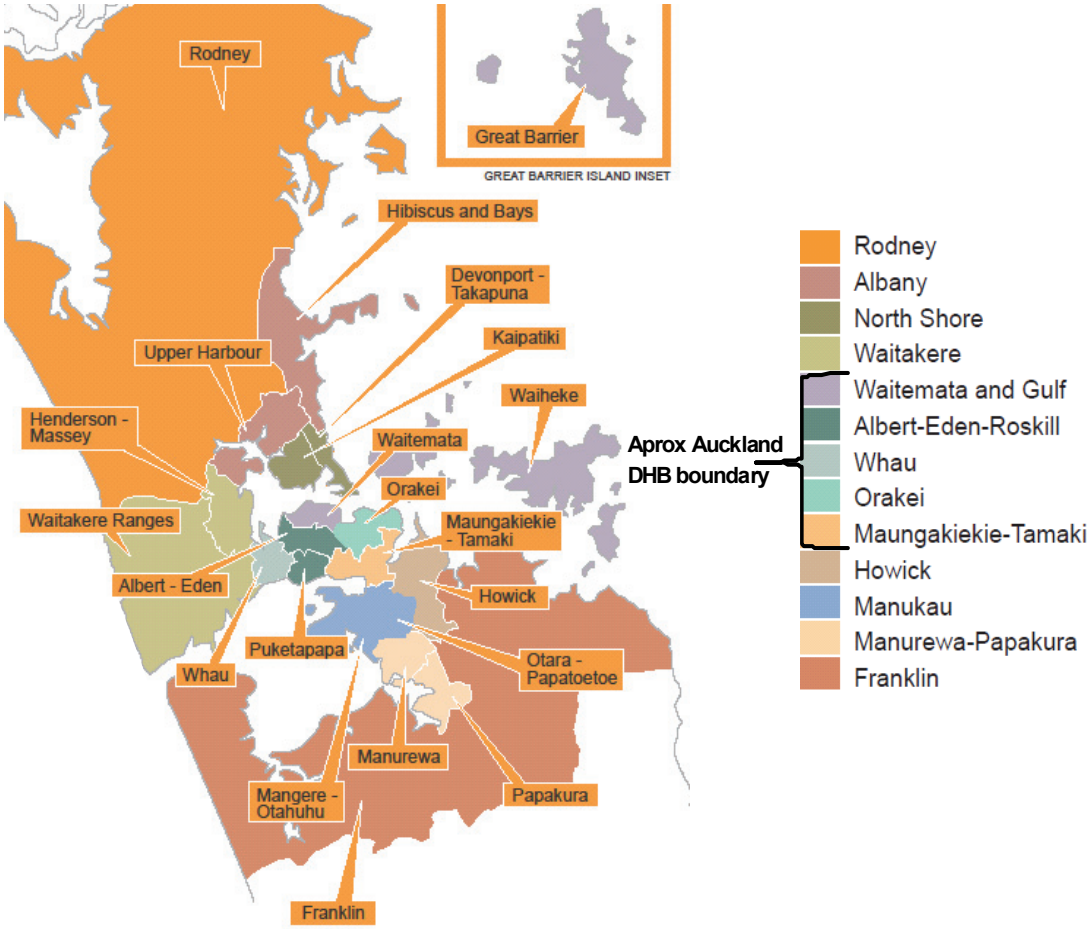
Up until 2010, Auckland DHB boundaries matched those of the Auckland City Council. The reorganising of boundaries in the Whau and Maungakiekie-Tamaki wards within the Auckland Council (the "SuperCity") means that Auckland DHB no longer shares a common boundary with the city. While the DHB population remains the same, the ward changes have created a problem when using ward boundaries (and census data) to profile the Auckland DHB population.

Auckland DHB spans five wards within the Auckland Council. 87% percent of people living in those five wards fall within the Auckland DHB boundary. The other 13% now live in either the Manukau ward (14,215), which falls within the Counties Manukau DHB catchment, or the Whau ward (38,900), which is within Waitemata DHB.

Of the five wards in our area, the most populated are Albert-Eden-Roskill (pop. 165,700), followed by Orakei (pop. 82,400). 39% of the Auckland DHB population lives in areas with New Zealand deprivation index of less than seven (10 is the most deprived). In the 2006 census Maungakiekie-Tamaki was the most deprived ward in our Auckland DHB area with 67% of people living in an area more than 6 on the NZ deprivation index. The least deprived ward was Orakei with 8% of this population living in an area with a scale of more than 6.

The Auckland DHB population is expected to be 460,500 in 2011-12.

Auckland Council encompassing the wards within the Auckland DHB



Picture modified from an image on the Auckland Council website

Health profile of the district

Poverty

Poverty contributes most to low life expectancy. Poverty is affected by ethnicity & gender

In self-assessed health status, there is a direct relationship between age, gender, ethnicity and income for all ethnic groups, except Pacific

People who are poor, Pacific and those in age groups 14–24 and over 65 years score their health the lowest

49% of Maori and 64% of Pacific people live in the most deprived areas of Auckland city compared to 25% of the 'Others'. Most Indians and Asians live in the Avondale-Roskill area – 46% and 33% of their populations respectively. The 'Other' populations are fairly evenly distributed across all Auckland wards

	The most populated areas in Auckland City are Albert-Eden-Roskill and Orakei wards – 35% and 18% of Auckland's population respectively. Most Maori and Pacific people live in the Maungakiekie –Tamaki ward – 39% and 46% of their populations respectively
	Many of our children (41% of all 0–4 year olds) live in the most deprived areas of the city
Maori	72% of non-Maori die over the age of 75 years of age compared to 16% for Maori
	Maori in Auckland are more likely (compared to NZ and to local non-Maori) to smoke tobacco and marijuana, to be obese and to drink alcohol in a hazardous manner
	Maori have higher years of lost life (YLL) rates than non-Maori
Pacific	32% of Pacific people die over the age of 75 years compared to 72% for non-Pacific
	Pacific people are far more likely (compared to New Zealand Pacific and to local non-Pacific) to be obese, smoke tobacco, and have a poor diet
	Pacific ethnic groups have higher years of lost life (YLL) rates than non-Pacific people
Asian, migrants and refugees	Auckland is one of the highest non-English, non-Maori speaking areas with over 100 different languages spoken
	Asian people make up 25% of Auckland's population. 36% of these are South Asian, and about 80% of this group are Indian
	13% of our population need assistance or interpreting when attending health services
	Asians have good health compared to 'Others'. There are lower risks for Asians for all the indicators of health, except for regular exercise and vegetables consumption
	For South Asian and particularly for Indian people, while there is a lower mortality rate from cardiovascular disease, they have the highest rate of hospitalisation for myocardial infarction and angina. They are the highest users for angioplasty and CABG operations
Disability	About 1 in 5 Aucklanders live with impairment; most commonly loss of functioning related to mobility, agility and hearing. The rate of disability increases as people age
	Poorly informed social attitudes remain the most common barrier for disabled people
Gender	Men die younger than women by at least 3–4 years (rates are improving for both genders)
	Men have poorer health than women: they smoke more tobacco and marijuana, have higher cholesterol, are more likely to be overweight and to have a poor diet
	Men are more likely to drink alcohol in a hazardous manner
	Men exercise more often than women
	Men assess their health as better than women except in the general health perceptions scores. In this area men assess their health as poorer than women

Multiple data sources, primarily the Ministry of Health, Health Survey and 2010 updates

1.2.3 Nature and scope of functions

Under the NZPHD Act, 2000, the Auckland DHB has three distinct roles:

Provider: the key provider of publically funded health services

Funder: funding the range of services required including managing budget within the funding allocation and all related financial constraints

Owner of Crown assets
Activity under these headings is described in detail in Module 5.

The Auckland DHB health care system

People living in the Auckland DHB catchment area have access to a range of services from prevention and health promotion, to specialist treatments and, when needed, hospice or palliative care. Some of these services are provided within the hospital which has over 80 separate specialty service areas. Other services are provided by GPs, pharmacies, dentists, Maori organisations and many other community-based, non-government organisations.

The total value of services is approximately 1 billion dollars for the Auckland DHB population. Some funding comes to the DHB directly from the Ministry of Health, e.g. public health services and from the Clinical Training Agency (for costs associated with junior medical training). Auckland DHB also provides services for people who live in other DHB areas; the value of this work is approximately $600 million i.e. we receive funds as payment for the services we provide to other DHBs.

In addition, we address the wider determinants of health through our work with local government, housing, employment, social development and education. During 2011-12 the four DHBs in the northern region will work more closely together. This will improve focus on shared strategic priorities and will ensure a better use of resources available in the region. It also recognises that Aucklanders are mobile and use health services across the metro Auckland city.

Public Health Services (health promotion, prevention and protection)

The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB under a contract with the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. Prevention and health promotion work helps to reduce downstream demands on DHBs for personal health services. The Auckland Regional Public Health Service delivers evidence-based and regulation-based public health services, grouped as follows:

Notifiable and Communicable Disease Control	Investigating the source of notifiable diseases and outbreaks and limiting the spread of infection (a mandatory function performed across the region, delivered according to legislation and using evidence-based protocols)
Regulatory functions	Physical environment regulatory functions, e.g. Drinking water quality, biosecurity (exotic mosquito surveillance), hazardous substances, recreational water quality, lead poisoning, and all other public risks associated with environmental hazards
	Implementation of the International Health Regulations 2005
	Alcohol and tobacco regulatory functions and harm minimisation
	Emergency management – responding to local, national and international public health emergencies, e.g. The ‘keep it out, stamp it out’ response to the H1N1 novel influenza pandemic
	Health promotion targeted at discrete populations or sectors in the region to achieve overall improvements in health and reduced health inequalities
Population screening	Public Health advice to District Health Boards on screening
	Management and oversight of the National Immunisation Register (NIR) and the National Cervical Screening Programme (NCSP) Register

Community-based providers

The Auckland DHB provider arm encompasses some community services: A+ Links Home Health Care, Rehab Plus, community mental health services, community child health and disability services. The District Health Board also contracts Non Government Organisations (NGOs) to provide health and disability support services for people living in the Auckland DHB area. Some services are covered by a regional contract and therefore cover people living across the wider Auckland region e.g. some general practice work, supported accommodation for people with severe mental illness. Laboratories, Community Pharmacies and Health of Older People are also funded by the Auckland DHB.

Primary Healthcare

Auckland and Waitemata District Health Boards are operating as a single primary care team across the two districts.

There are five primary care organisations in the Auckland and Waitemata DHBs as part of the government's Better, Sooner, More Convenient Primary Health Care policy, they are aligned with three region-wide primary care entities/consortia which cover over 95% of the metro Auckland population. These entities are: Alliance Health Plus (AH+); Greater Auckland Integrated Health Network (GAIHN); and the National Hauora Coalition

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

These business cases integrate PHOs across the DHB boundaries. This means closer involvement of other services for patients and increased clinical leadership in health decision making. New service developments in primary care are committed to Whanau Ora – the Maori approach to health and wellbeing.

Auckland DHB supports the implementation of primary care work plans. The desire to have more services available via GPs, along with other community-based providers, depends on direct support from hospital-based clinicians as well as staff involved in hospital management. Actions for the 2011-12 year develop the projects approved as part of the original 2010-11 business cases. These are detailed in Module 3.

The Auckland DHB provider (hospital and related services)

Auckland DHB provider arm includes Auckland City Hospital, the Greenlane Clinical Centre and a number of community-based services.

Auckland City Hospital –	Acute adult medical, surgical and older people's health services
	Acute mental health services including the Child and Family Unit
	Child health services provided by Starship Children's Health
	Women's health and maternity services provided by National Women's Health
Greenlane Clinical Centre –	Provides advanced outpatient, ambulatory services, and short-stay surgical care

Community-based services –	Rehab Plus, older people's community based services, home health, community mental health services, community child health and disability services

Characteristics of the Auckland DHB hospital system

Auckland DHB operates New Zealand's largest public hospital with almost two million patient contacts each year, including local hospital and outpatient services for 446,000 Aucklanders. The hospital also has the largest elective surgery delivery system in New Zealand with 22,000 elective discharges, approximately 52% of which are for other DHB populations.

There are approximately 10,000 staff employed in the provider arm which equates to a little over 7,700 full-time equivalent positions (FTE). Auckland DHB is the largest trainer of doctors in the country with approximately 1,477 medical staff of whom about 685 are in various stages of training. The hospital is also the largest clinical research facility in New Zealand, engaging in work that attracts funding and participation here and overseas.

The National Forensic Pathology Service is run at the hospital under contract with the Ministry of Justice. The National Newborn Screening Service is run under contract with the National Screening Unit.

Over half the work done within Auckland DHB hospitals is for people who live outside Auckland city. Some tertiary services (e.g. clinical genetics and paediatric oncology) are provided for people in the Northern, Midland and Central regions.

Auckland DHB is a specialist centre for the region and the rest of the country, providing tertiary services for the northern region (about 1.6 million people). Amongst the specialist services provided for the whole of New Zealand are:

- organ transplant (heart, lung and liver)
- acute major airway obstruction transferred for laser or stent placement
- massive haemoptysis transferred for surgery or bronchial arterial embolisation
- hepatic laceration requiring acute hepatic surgery
- paediatric Intensive Care Unit transfers
- paediatric cardiac services
- epilepsy surgery
- deep brain stimulation
- high-risk obstetrics

Auckland DHB provider arm also provides some community services: Rehab Plus, A+ links home healthcare, community mental health services, community child health and disability services.

Auckland City Hospital is a receiving hospital for cases outside Auckland DHB catchment across specialities including acute and elective cases. Transferred cases tend to be higher complexity and contribute to longer length of stay e.g. approx 50% of Auckland DHB provider arm patients are from outside the Auckland DHB catchment, Starship Children's Health provides sub speciality services nationally, with referred work contributing up to 70% of the throughput for some units, oncology biopsies and renal transplant donors, complex obstetric cases.

Many of these services are only provided in New Zealand by Auckland DHB. In many cases they depend on a small number of highly specialised staff. There is an associated vulnerability created by relatively low volumes and international competition for staff.

- diabetes because of its growth and the workforce constraints
- Older Peoples Health because of the same

Other services have been identified as vulnerable through the regional health planning process:

- Head and neck (complex high needs service)
- Neonatal services (number of cots too low for region)
- Bone marrow transplant service (workforce and physical capacity)
- Maxillofacial surgery (workforce)

Specific deliverables for the hospital and hospital-related services in the 2011-12 year are covered in module 3. In summary these focus on the national health targets and priorities, on achievement of our northern region goals, and on efficiency and productivity gains.

1.2.4 Operating environment

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

Managing the funding

Auckland DHB received a total increase of $43.6m (2.8%) in the December 2010 Funding Envelope. This increase is made up of $17.6m for services delivered for other DHBs and $26m as population based funding. The population based funding increase is $1.6m for additional national services, a contribution to cost growth pressure of $15.7m and a contribution to demographic growth of $8.7m.

Auckland's share of the additional funding that was made available to DHBs to manage their demographic growth pressure is lower than its relative population. This is because its resident population has been moving, on average, to a lower health need and reduced socio-economic disadvantage position compared to other DHBs. However, Auckland DHB's intervention rate under national expectations is higher than the demographic funding increases received.

The various Funding Envelope components are shown below, based on Ministry of Health advice received in December of the preceding years; and thus allowing a 'like for like' comparison. Over the year, there are usually some adjustments made on Inter District Flows and other items such as devolution of services and other national services, leading to ongoing revisions of the Auckland DHB's Funding Envelope amount.

Funding Envelope summary changes from 2010-11 to 2011-12 ($m)

Funding Envelope component	2010-11 $m	2011-12 $m	% change	
Funding for Auckland DHB services (Pop. Based Funding)	822.1	846.4	2.9%	PBF Increase 2.6%
Funding for services for Auckland population at other DHBs	100.8	100.9	0.1%	
Funding for the provision of national services (Top-Slices)	38.3	39.9	4.2%	
Funding from other DHBs for treating their residents (Inter District Flows)	582.9	600.5	3.0%	
Total Revenue $m	**1,544.1**	**1,587.7**	**2.8%**	

The Funding Envelope together with various national service priorities and local population demand has implications for Auckland DHB:

- Direction to increase utilisation of community pharmaceuticals, which is estimated at an additional $1m cost to Auckland DHB above its normal population growth demand – due to a Government commitment given to increase spending on community pharmaceuticals. This excludes the flow-on cost of additional scripts which is paid directly by Auckland DHB to pharmacies within the district
- Aged Residential Care growth – Government expectation is that price payments will be increased by 1.72%
- PHO/Primary Care – rates for 'first contacts' are to be increased by 2%
- Elective Services to be increased by at least 860 case weighted discharges (approximating an 8% increase in work well above the funded population growth rate; $4.5m).
- Acute services – there is apparent demand over and above the population growth rate
- Ministry of Health and the National Health Board have advised of a review of the less than 65 years of age Disability Support Services purchased by the Ministry of Health. For the 2011-12 year, the National Health Board intends to adjust the inpatient volumes to reflect 'historical delivery' (rather than actual in 2010-11) as well as adjust the unit price. Early estimates indicate that for Auckland DHB, there may be a revenue reduction of $2m
- Policy changes have been made to the payment of 'adjusters' for national specialist services traditionally provided at Auckland DHB. For instance, there will no longer be a separate $16m payment for national paediatric services (Starship); instead, this cost is now part of the overall Auckland DHB adjuster pool allocation. At the same time, however, the national reference price for case weight discharge has been increased and the adjuster pool has been reduced by 33% from $115m. Nationally, these changes are at a 'zero sum' and the decrease in adjuster pool funding and increase in case weight price will off-set each other; as long as the current system equilibrium is maintained. However, for ADHB which is a large recipient of Inter District Flows (IDF), there is a net reduction in revenue.
- Mental health services have been funded at the 'ring-fence' expenditure requirement placed on Auckland DHB (i.e.$125m), despite the Population Based Funding share of funding received by Auckland DHB for mental health being considerably lower (at $118m)
- There is no service reduction planned for the Child and Family Unit (mental health) associated with FTEs, but there is a small reduction in bed numbers for the metro DHBs. This results from a service redesign in which Northland DHB has withdrawn from accessing Child and Family Unit services as they set up their own. Auckland DHB has

agreed to increase the number of beds available to the Midland region. Overall the number of beds in Child and Family Unit will remain the same after Northland exit
- The planned price reduction of 3% to NGO-provided services resulted from an error in our Production Plan. The variance between 2010-11 and 2011-12 in NGO services now vary from reductions in some Purchase Units offset by increases in others. The net increase for this period in NGO provided services is 5.3%. This increase, together with budgeted efficiencies in the NGO sector, recovery from WINZ, and taking into account the current level of underspend, will result in the same level of service planned for the majority of NGO services, with increases in Eating Disorders and inter district flows
- There are also services which are provided to Auckland district residents by, and at, other DHBs; for which payment of $100m has been forecast for 2011-12
- The ongoing implementation of Better, Sooner, More Convenient strategies and initiatives (outlined in Module 3 and as approved in the Northern Regional Health Plan for commencing in 2011-12) is resourced at 2010-11 spend plus growth in line with Funding Envelope expectations.

Principles for the allocation of funding

The principles are to:

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

As a result:

- organisational budget cost levels for 2011-12 have been proposed for Auckland DHB to remain within budget overall. The managers will be expected to manage their 2011-12 costs to within the targets whilst delivering the identified service volumes
- a 2011-12 production schedule has been prepared, in consultation with hospital services, for both case weight acute/elective service, and non-case DRG services. In this, hospital acute services will be increased at a growth rate to match the forecast production at 2010-11 plus the projected population growth over 2011-12
- electives will be an overall 7% increase from current targets across a range of surgical procedures (joint, cataract and cardiac, as well as a 30% increase in Bariatric surgical volumes required by the NHB to 41 cases in 2011-12). Cardiothoracic electives will be set at population growth level only, because currently there is a low and acceptable waiting list and wait times, and any increase shifts resources away from other priorities
- oncology volumes will be increased to reflect the impact of an anticipated radiation therapy intervention rates increase, due to the Ministry of Health four week target together with forecast increases in chemotherapy regimes
- NGO and other non-provider community services have undergone a prioritisation review over the last year and subject to cost growth restraint. However, it is noted that services relating to community pharmaceuticals, Health of Older People and Primary Health Organisations are linked to national decision-making and legislative entitlement.

Service and Volume Change from 2010-11 to 2011-12

Service volume targets for Healthcare Service Groups have been set, taking into account:

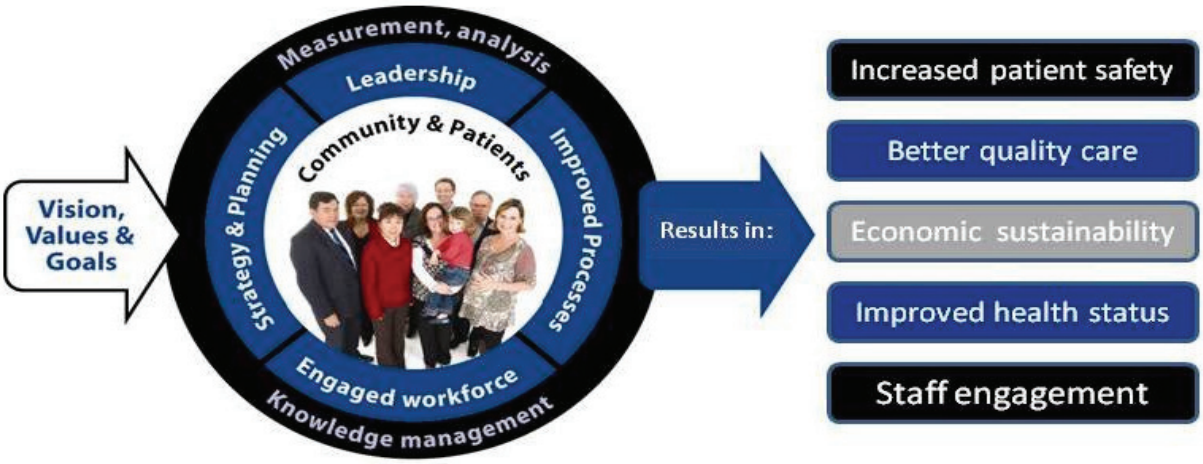
- Levels of acute growth, including the work from other DHBs

- Elective performance and management of elective target increase requirements
- Performance of referrals for specialist assessment and link to the elective targets
- Performance of treatment follow-ups and on the need to reduce activity in this area as Auckland DHB cannot continue to have increased follow ups at the expense of other treatments
- Diagnostic procedures, e.g. access to scopes. This is an increasing area of growth and future demand needs to be carefully considered
- Treatments and discharge – often patients start treatment which is ongoing, e.g. avastin; and careful consideration of how this will be managed
- Support services, e.g. ongoing laboratory and radiology requirements
- Known service changes –service shift(s) to another DHB, movement to a primary care setting, or alternatively, new service innovation is underway.

Module 2: Strategic Direction

2.1 Auckland DHB's Drive to Improve Performance

2.1.1 Healthcare Excellence



Healthcare Excellence our Performance Improvement Framework

Transforming to Healthcare Excellence is our community and patient-centric performance improvement framework at Auckland District Health Board. By introducing Healthcare Excellence we aim to provide the best healthcare in New Zealand and be the best healthcare provider to work for. It commits us to a journey of continuous improvement building on the good things we already do to ensure we are the best we can be today whilst embracing new ways of working to deliver excellence into the future. It involves all our staff in Auckland District Health Board and other health professionals and communities who help us deliver our vision of healthy communities and quality healthcare.

Healthcare Excellence is based on the internationally recognised performance framework Baldridge Criteria, which is used in many organisations around the world including, Vero, the New Zealand Navy, Mercy Health System (USA) and Sharp Healthcare.

The framework connects our vision, goals, mission and values to guide how we develop our organisation's culture, capability and processes to deliver superior results now and into the future in the following key result areas: patient safety, quality, health status, staff engagement and economic sustainability.

While we are a very good organisation with much to be proud of and have benefited from the good work of a lot of good people, we believe we can do much better for our community and patients. We have many inefficient processes caused by patched-up, over-stressed systems; we have too many adverse events that cause harm; our services aren't designed for patients and their families; we have health status disparities in our population; we face reduced growth in funding that requires innovation in service delivery; and we have not fully engaged all our staff in improving the performance of our organisation.

We are positive about the change in mindset that will be required to make this transformation necessary as below.

From	To
Provider first	Patient first
Errors are to be expected	No harm
Waiting is good	Waiting is bad
Reduce labour cost	Reduce waste, complexity and variation. The uniqueness of our patients should be our only variation
Optimise sub systems	Optimise the whole system including suppliers and customers
Leadership oversight	Leadership on site
We have no time	We have time
Variable accountability	Rigorous accountability
Add resources	No new resources necessary

2.1.2 Clinical Leadership

Authentic Clinical Leadership will be required to own and drive the Healthcare Excellence framework to make the changes necessary to deliver the results we believe are possible. This will require developing clinical leaders' management skills, continuing to focus on developing effective clinical and management partnerships at all levels, developing clinical networks across care settings; ensuring effective governance is in place for medical, nursing and allied health professionals.

We have clinical leaders with delegated authority at four levels of management within ADHB. GP liaisons officers are employed by Auckland DHB but work is required to improve primary and secondary relationships to realise the potential of the system.

2.1.3 Healthcare Service Groups (HSGs)

To deliver better integration and to drive health system improvement both within and between hospital and community services, we have created 6 clinically led Healthcare Service Groups.

- Children
- Women
- Adults
- Mental Health and Addictions
- Cancer and Blood
- Cardiovascular

We want the Healthcare Service Groups to innovate. There must be a focus on creating a higher performing health system with increased emphasis on service delivery and outcomes. We must also deliver more given the resources available. We must be organised to deliver the right amount of care at the right time in the right way. The Healthcare Excellence Framework will give us the tools to do this driven by our clinical leadership.

2.2 The national, regional and local context

This Annual Plan is developed by the District Health Board to demonstrate our commitment to contributing to health gain, within our DHB area, within the region and within the country. We will align our activities for our local population to the wider health sector goal of Better Sooner More Convenient healthcare for all New Zealanders. The Plan aligns to our Maori Health Plan which is in development.

2.2.1 Government priorities

Auckland DHB will focus on the six national health targets with particular emphasis applied to electives and waiting times for emergency department services. There is also a larger suite of national performance measures which DHBs are required to achieve. The Minister of Health has also outlines a set of additional expectations for the 2011-12 year.

Health targets

Six national health targets

- Shorter stays in Emergency Departments
- Increased immunisation
- Improved access to elective surgery
- Better help for smokers to quit
- Shorter waits for cancer treatment radiotherapy
- Better diabetes and cardiovascular services

National health priorities (see appendix 1)

Policy priorities

- PP1 Clinical leadership self assessment
- PP2 Implementation of Better, Sooner, More Convenient primary health care
- PP3 Local Iwi/Māori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain
- PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Māori
- PP5 Waiting times for chemotherapy treatment
- PP6 Improving the health status of people with severe mental illness
- PP7 Improving mental health services using crisis intervention planning
- PP8 DHBs report alcohol and drug service waiting times and waiting lists
- PP9 Delivery of Te Kokiri: the mental health and addiction action plan
- PP10 Oral Health DMFT Score at year 8
- PP11 Children caries free at 5 years of aged
- PP12 Utilisation of DHB funded dental services by adolescents
- PP13 Improving the number of children enrolled in DHB funded dental services
- PP14 Family violence prevention
- PP15 Improving the safety of elderly: Reducing hospitalisation for falls
- PP16 Workforce - Career Planning

System Integration Dimension

- SI1 Ambulatory sensitive (avoidable) hospital admissions
- SI2 Regional service planning
- SI3 Service coverage
- SI4 Elective services standardised intervention rates
- SI5 Expenditure on services provided by Māori Health providers
- SI7 Improving breast-feeding rates

Ownership Dimension

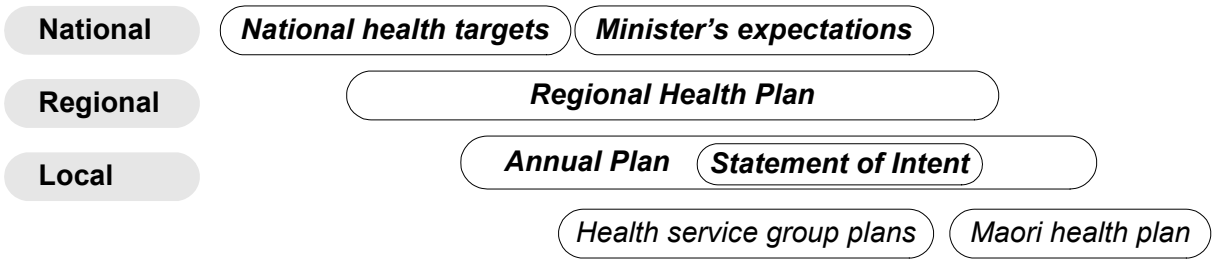
- OS3 Elective and arranged inpatient length of stay
- OS4 Acute inpatient length of stay
- OS5 Theatre Utilisation
- OS6 Elective and arranged day surgery
- OS7 Elective and arranged day of surgery admissions
- OS8 Acute readmissions to hospital
- OS9 30 Day mortality
- OS10 Improving the quality of data provided to national collection systems

Output Dimension

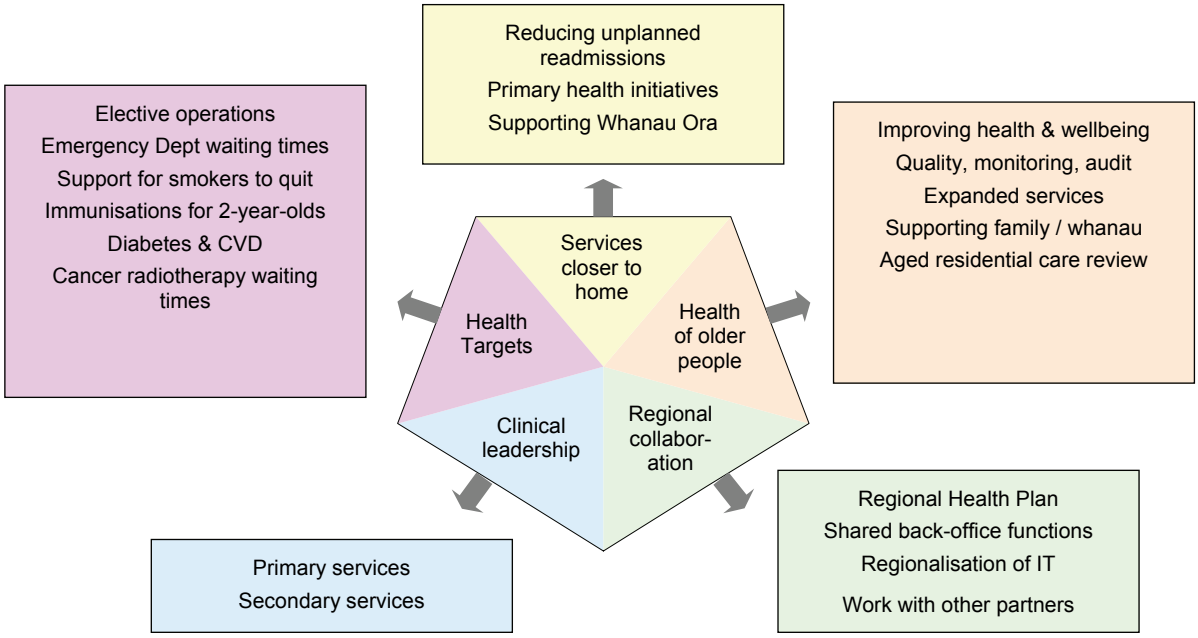
- OP1 Output Delivery

These targets and other national measures of DHB performance are covered in detail in Appendix 1. Actions that help to achieve these government expectations, such as health targets, priorities and expectations are included in module three.

The hierarchy of health sector plans



The Minister of Health's letter of expectations for 2011-12



Expectations of Auckland DHB

1. Improved services / reduced wait times	Achieve the 6 national health targets aimed at improved patient care Continue to improve waiting times Improve elective surgery rates
2. Clinical leadership	Strengthen clinical engagement and patient care. Clinical input from bedside to boardroom Improve the job satisfaction of the health workforce Work with neighbour DHBs to further support clinical networks, with clinicians leading the development and operation of each of the priority services, and the integration of services closer to home
3. Services closer to home	Government wants Better, Sooner, More Convenient healthcare for New Zealanders. Strong priority is given to improving frontline services within available resources. Despite the tight financial times, Government has increased Vote Health by more than $1.2 billion over two years, reflecting a determination to protect and grow public health. There will be integration of services across hospital and community to improve convenience for patients and to reduce the pressure on hospitals Refocus more resources to delivering services in local community settings, closer to patients, with particular attention to: • reducing unplanned admissions by working with community and hospital clinicians on: chronic disease management, the frail elderly, after-hours • ensuring clinicians are at the forefront of development, are supported by management and enabled to provide services more effectively • developing efficient and effective integrated family health centres • supporting the Whanau Ora initiative Engage doctors, nurses, pharmacists and allied health professionals in this work
4. Health of Older People	Re-orient services to meet health and support needs: • improve older people's underlying health and wellbeing - particularly mental health (dementia) and preventing disease and injury • build better systems - including using standardised tools to improve quality across home-care and aged residential care • provide new and expanded services: dementia, and primary and community care improvements to avoid hospital admissions • support family/whanau - in particular provide access to respite care, day programmes and social supports
5. Regional Collaboration	Significant development of regional collaboration: • regional plans, focused on a small number of high priorities and the most vulnerable services in each region, with implementation plans to quickly and sustainably secure these services • develop shared back-office functions across DHBs • regionalise IT platforms, IT support and workforce development

The Long Term Health Sector Plan

Government passed the New Zealand Public Health and Disability Amendment Bill in 2010 to help meet the many challenges faced by the public health and disability system. The amendments provide the statutory framework for the National Health Board and DHBs to establish a more deliberate approach to ensure which services should be planned, funded and provided at the national, regional and local levels. They also put a much stronger emphasis on DHB collaboration to plan health services regionally. Changes in the Act and its regulations are designed to support better planning across the sector.

The Long Term Health Sector Plan will:

- outline the future direction for public health services
- focus on service planning and new models of care
- provide high-level direction over the next 20 years
- describe the challenges the sector faces
- provide options for models of care that offer solutions and implications for the way services are configured in future
- guide future decisions about service configuration and investment at all levels of the system
- support district health boards in their long term local and regional planning

The National Health Board will use the Long Term Health Sector Plan to inform their review of national, regional, and district plans.

National service improvement programmes

A working group has been established through the National Health Board and DHB Joint Oversight Group to assist with the next phase in the development of national services. The group includes a Chief Medical Officer, a Director of Nursing, a Director of Allied Health, a Chief Operating Officer and GM Planning and Funding from each region.

Services to be planned and funded nationally from 2011- 12

Service	Rationale
Clinical genetics	Enabling families, no matter where they live, to be able to access clinical genetics for screening and counselling to prevent unnecessary pain, hardship and loss as a consequence of genetic conditions
Paediatric pathology	Ensuring a stable work setting to retain critical staff members in paediatric pathology and prevent the service having to move to Australia, or delivering a lower quality of services to families who have lost their children
Paediatric metabolic services	Ensuring a stable work setting to retain critical staff members and preventing the service being discontinued. This service is important in addressing the consequences of metabolic disease in children resulting in increasing incidence of Type 2 diabetes. Developing this service may also assist with managing the large impact of high cost drug utilisation
Paediatric cardiology & paediatric cardiac surgery	Ensuring that all children across New Zealand, with cardiac disease, are able to access this service in a timely manner and prevent unnecessary mortality and death

Services within the National Service Improvement Programmes

Service	Rationale
Cardiac surgery	More work is required to support cardiac surgical improvements so adults access cardiac surgery in a timely manner, preventing unnecessary death. The clinical network will expand to cover broader cardiac issues
Paediatric oncology	Ensuring that paediatric oncology, which produces some of the best cancer survival rates in the developed world, continues to service our children and ensures no breaks in service continuity
Paediatric gastroenterology	Ensuring equitable access to paediatric gastroenterology for children across New Zealand when very specialised services are required
Neurosurgery	Ensuring neurosurgical services are available nationally. Consistent and safe access prevents unnecessary loss of life by preventing unplanned service closure and supporting the development of neurosurgical subspecialties
Major trauma	Creating a nationally consistent approach to the management of major trauma, ensuring effective access to the right services to prevent avoidable loss of life

2.2.2 Regional planning

Working with other DHBs maximises the best use of the resources available and unleashes greater potential for health gain for people living in the region. It also acknowledges the mobility of Aucklanders across the metro area, particularly in the use of health services.

The Regional Health Plan for the Northern Region (Auckland, Counties Manukau, Waitemata and Northland DHBs) outlines the longer term goals for the region and areas of primary focus for the future. Regional work begins to address some of the challenges we face from high population growth, ageing and disease trends, also around our workforce shortages and ensuring the sustainability of the region's services.

We are contributing to the achievement of the Northern Region Health Plan through:

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

We will also contribute through the achievement of specific actions within the plan. Activity for the 2011-12 year is included in module 3, section 11.0. What Auckland DHB will deliver and the timeframes for doing so will be detailed more fully in the Northern Region's Implementation Plan, due for completion July 2011.

Strategic challenges for the northern region

The Northern Region Health Plan identifies challenges to address in the medium term:

- there are disparities in health status and health outcomes linked to ethnicity and socio-economic deprivation

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

The agreed direction for our region is set out in the Northern Region's Charter. Our mission and the Triple Aim help us focus on priority areas of focus as below.

First, do no harm	Focuses on patient safety and improving quality	Start a clinically-led campaign to progress and be accountable for quality and patient safety initiatives One overarching strategy and a consistent methodology to developing a patient safety culture across hospitals, residential care, and primary care, with initiatives to reduce pressure injuries, falls and central line acquired bacteraemia
Life and Years	Achieves longer, healthier more independent lives for the people in our region Focuses on diabetes, cardiovascular disease, health of older people and cancer for the 1st year of the plan Dampen the upward trend of incidence of key diseases, and closing of the life expectancy gap	Specific initiatives targeted for: – Cancer – CVD – Diabetes – Health of older people Get greater consistency in clinical pathways so patients get the same care regardless of where they present Improve the quality of data and patient information we have available so we can identify problems and fix them
Informed patient	Ensures that patients get care, information and support aligned to their individual need, particularly whanau ora assessment and advance care planning Reduce the gap in inequalities and will achieve better engagement with Maori, Pacific and high needs populations around their health More people will be able to plan how and where they die	Whanau Ora assessments and case management as required – for Maori, Pacific and high needs whanau, to improve the assessment and management of disease and health literacy Advance Care Planning – standard process across health care to give patients, along with families and clinicians the opportunity to participate in planning their end of life care

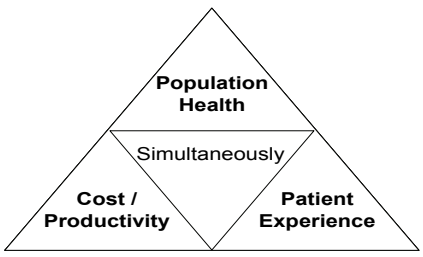
In addition to these priorities we will help to achieve regional results on the national health targets, providing more affordable services and aligning capacity to demand. We also need more collaboration around information technology, workforce and facilities.

Workforce	Build clinical leadership capability so health professionals can participate in service design and delivery, with full participation in decision making from the front line through to the board room
	Establish three centres of excellence as key resources for the region. These will grow tomorrow's clinical and management leaders, and support the region's role as a leader of innovation and education
	Establish a Regional Training Hub for RMOs in the region
	The workforce will grow in line with this plan – increasing the number of nurse specialists in cardiology and diabetes – increasing support workers for health of older people
	Use our workforce in different ways so that primary care clinicians provide more specialist support for their patients through mentoring with secondary clinicians
Information systems	One Information System organisation across the region, delivering prioritised initiatives for a single patient administration system, single clinical workstation, development of repositories for clinical data and population health, and building the resilience of the IS infrastructure
	Initiatives that assist clinical staff to effectively manage patients across all care settings
Facilities	We will manage the need for patients to come into our hospitals and their journey through them so we won't need to grow our bed numbers at the same rate in the future
	Initiatives that enable us (longer term) to hold bed growth to within that required for demographic growth
	We will help to develop Integrated Family Healthcare Centres and Whanau Ora Centres, with 3 initially planned
	We will also work differently to manage our patients with high health needs, particularly older people and those with CVD, diabetes and cancer

The Northern Region Health Plan Charter

Our Mission:

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



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

Strategic goals for the northern region

Objectives and expected outcomes

1. Population health	2. Patient experience	3. Cost productivity
1.1 Minimise impacts from diabetes and cardiovascular disease 1.2 Improved quality of life for older people and their family / whanau 1.3 Improved quality of life for people with mental health and addiction problems and their family / whanau 1.4 Healthier safer children 1.5 Minimised impacts from cancer	2.1 Improved quality of health care 2.2 Improved safety of health care 2.3 Expanded range of services available in the community	3.1 Appropriate health & disability services are accessed in a timely manner when needed 3.2 Regional resources are used effectively & services delivered efficiently with minimal waste 3.3 The health needs of the community have been anticipated with appropriate investment in workforce & staff mix 3.4 Manage infrastructure & assets to ensure safe, efficient and effective services 3.5 Work in partnership to influence health & wellbeing outcomes 3.6 Information systems & technology

The region has agreed a number of service change priorities for 2011-12. These service changes have been signed-off by the respective DHBs and the impacted DHBs have agreed to start the planning process to detail the implications of change and subsequent plans of action. These include:

- Cardiology
- Renal
- Ophthalmology
- Maternal medicine
- Vascular surgery
- Paediatric medicine
- Second trimester termination of pregnancy service

Further description of the service changes is included in module 8. Information about the Northern Region Health Plan is available at:
http://nshint02.healthcare.huarahi.health.govt.nz/nrhp/

2.3 Risks and opportunities

The following material relates to any risks associated with the implementation of this Annual Plan. It does not cover all the risks we are exposed to in the normal management of District Health Board business. A full register of risks exists and is constantly updated.

1. Lift the health of people living in Auckland DHB

Auckland DHB is responsible for planning and funding the majority of health services provided for its resident population as well as a number of regional and national services. Critical or major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
There is significant growth in the Health of Older People area, driven by legislated entitlement to care (and home based support services if the distribution of service level is of a higher acuity than planned) We have funding for this, budgeted on past history, but nevertheless potential for over budget expenditure exists	Continued implementation of the new Home Based Support Services framework which matches payment to complexity The InterRai system will support consistent assessment processes Close monitoring and working closely with the providers
Population Based Funding imbalances don't recognise funding requirements for our population i.e. the growth in population is higher than forecast in Population Based Funding and is associated with emerging health needs. Also Population Based Funding does not recognise the specific disease burden, and other skews in the Auckland DHB population	Continued discussions with the Ministry of Health regarding population skews and also new ethnicity related health needs Productivity improvements to deliver more outputs from the available inputs We need to assess the impact from changes to the City Council ward boundaries, particularly where these impact in Inter District Flows
Development of Long Term Conditions management programmes are being impacted by the ongoing development and speed of the primary care business cases	Close involvement in primary care business case development and respective implementation plans Work closely with other DHBs in the region
The prevalence forecast for Diabetes and CVD has increased from 21,000 (2009) to 25,000 (2010). This level of increased volume makes it difficult for the district to not only absorb these increases but increase the target to be achieved The establishment of a national target of 90% for CVD risk assessment is 10% greater than our current achievement. Currently we improve by	By maintaining our 2009–2010 targets for most groups still equates to an increase of 3,033 free diabetes annual checks, and an increase of 2,430 individuals with and HbA1c <8% Discussions with the Local Diabetes Advisory Team and other colleagues concluded that with the prevalence increase, maintaining our current targets with a slight decrease for Pacific would be appropriate and achievable Three Long Term Conditions quality improvement coordinators have been established to support primary care in systems review and changes. Their focus will be on both diabetes and cardiovascular

Issues and risks	Mitigation strategies
1%-2% per annum	risk assessment and management A regional cardiology network has been formalised and chair appointed. They will provide leadership and guidance to direction for improving cardiovascular risk assessment
Regional primary care business case activity fails to achieve promised improvements	DHBs are committed to ensuring the success of the three Primary Care business cases operating in the Auckland region and will continue to resource them to succeed within DHB budget parameters A shared understanding and approach to locality based health planning and delivery is key to achieving the promised improvements. DHBs are working toward this.

2. Performance improvement

Critical or major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
Acute demand greater than predicted	Management focus on unit cost reduction, productivity improvement and patient pathway development (primary care business cases)
Emergency Department attendance numbers are increasing. On review, these attendances were appropriate. They included an increased number of referrals for Cardiovascular concerns and diabetes related complications. This increase may be attributed to improved diagnosis within primary care and is an outcome that is highly desirable	Some of the increase in Emergency Department presentations may settle once the screening tools for CVD and diabetes used in primary health care are more embedded into practice Having more specialist clinicians assisting the primary care sector will also ensure that more specialist CVD and diabetes work is managed in community settings
Increasing Emergency Department presentations reflect true population growth, changing inner city demographics and case mix relating to such. Growth is across all triage categories except 5 and attendances are appropriate for ED	Primary care initiatives including Primary Options for Acute Care, clinical pathways, and GP access to diagnostics will have some impact Reducing the impact of alcohol on 19-24 age group will require public health approach Planning is well advanced for anticipated growth in attendances during the Rugby World Cup
Ability to resource information system initiatives (demand > supply)	Implement regional and local prioritisation process to ensure agreed programme of work can be delivered with existing resources Maximise opportunity for regional and national collaboration to share resources and outputs

Issues and risks	Mitigation strategies
Support resources (information systems, procurement, HR, etc) drop in productivity during distraction by move to increased collaboration and shared services IT infrastructure resilience and limitations meeting National Health Board expectations	Where appropriate develop appropriate change management plans and monitor key DHB deliverables closely during change process
Workforce supply and demand pressures creates shortages in some areas linked to health improvement priorities e.g. radiation therapists, physicists, radiation oncologists, operating room staff and midwives We also need to factor in the likelihood that some of our workforce might leave NZ because of the Christchurch earthquakes	Targeted recruitment plans Understanding the drivers of turnover for these groups and implementing appropriate interventions The regional cancer service will continue to work proactively to increase placements in cancer specialities via national training programmes as well as international recruitment Retaining specialist staff remains a focus. Work will continue with Health Workforce NZ re Radiation Therapy and the Physicist workforce modelling
The rate of elective service delivery will become increasingly difficult to achieve given the population based funding anomalies in the Auckland DHB population. We have an aged care service that significantly exceeds the population revenue Auckland DHB receives for that population. While Auckland DHB has the lowest elective intervention rates nationally, we had the 4th highest increase in elective surgery delivery over 4 years 2005 to 2009. This increase shows Auckland DHB commitment to increasing access for its population	Adopting this target underscores Auckland DHB's commitment to increasing its elective surgical rates for its population Auckland DHB expects to work with the Ministry of Health during 2011-12 to address these and other Population Based Funding imbalances to support the government's electives services strategy and to ensure fair access for the Auckland DHB population
Significant volume growth is forecast for both radiation oncology and medical oncology for the next 10 years within the northern region There is also the cost of excess capacity required to sustainably meet the Minister's health target. There is a risk that funders will not be able to reprioritise from other areas of health spend to meet this cost	A regional governance approach to managing oncology services Negotiation of outsourcing costs
The organisation is undergoing significant change, some of which requires considerable culture change to be sustainable e.g. implementation of the Healthcare Excellence Framework. The overall programme of change is ambitious and will require leadership over the longer term	We have strengthened our clinical leadership structure, and are investing in improvement activities to engage front-line clinical staff
The Auckland DHB target for inpatient stays is 4.00 and exceeds the national target. Because	Move towards an average length of stay of 3.92 for 2012-13

Issues and risks	Mitigation strategies
of high-end complex service provision, we have slower progress in reaching the national ALOS target Auckland City Hospital receives cases outside our catchment across specialities, including acute and elective cases. Transferred cases tend to be higher complexity and contribute to longer length of stay. Approx 50% of patients are from outside our DHB area, Starship Children's Health provides sub speciality services nationally, with referred work contributing up to 70% of throughput for some units, oncology biopsies and renal transplant donors, complex obstetric cases	

3. Live within our means

Auckland DHB continues with its objective of maintaining a break-even financial result. Critical and major issues and risks impacting on achievement of this goal include the following.

Issues and risks	Mitigation strategies
Production at higher volume levels may exceed marginal costs, particularly in resource-intensive services e.g. surgical	Careful budget control, productivity improvement and cost efficiency gains
Lead time(s) to develop appropriate capacity may delay delivery	Service and pipeline capacity planning
Unbudgeted high level of acutes	Trade-off analysis and management with other services
High growth in demand due to legislative entitlement and demographic growth (Aged Residential Care); and similarly health gain initiatives and extra funding for drug use by Government policy will increase Auckland DHB spend on pharmaceuticals	Aged Residential Care – continue with Home-based support services development to relieve pressure on rest homes Pharmaceuticals – participate in national DHB/Pharmac initiatives (including closed control) to manage drug use and dispensing costs
NGO sector has not had a cost or demographic adjustment for the current year and there are expectations of recognition by Auckland DHB of the fiscal impact of cost and demand growth	Close review on a case by case basis and link to demonstrable impact of cost or demand
The current level of funding available to Auckland DHB, at the minimum increase level, may prove insufficient for the scope and scale of services that are demanded over the year	Close management of cost of service and support of productivity improvement and cost containment strategies within available resources

Issues and risks	Mitigation strategies
The impact of the primary care business cases and any subsequent devolution has yet to emerge	Work closely with the primary care business case groups to identify and develop appropriate budget requirements
Budgets are based on assumptions and predictions of future activity. This carries a risk that future events are not in accordance with these predictions	Processes for monitoring variations are established so that actions can be identified to address any variation. Close monitoring of volumes
We have budgeted to achieve a break even position within the allocated funding and to manage the various environmental factors that impact on budget	Reprioritise and reallocate resources and carry out initiatives in clinical resource use and practice changes, productivity improvements, reduced administrative costs and procurement savings
Regional Health Planning work i.e. the implications of the Northern Region Health Plan and management of assets regionally	The Northern Region Health Plan will be used to inform the prioritisation of resources within the allocated funding

Module 3: Priorities and health targets

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

3.1 Work priorities for 2011–12

1.0 Improved services / reduced wait times: shorter stays in Emergency Departments

We take action	To deliver for communities and patients	As measured by
1.1 We will improve the acute patient journey to ensure patients' length of stay is right for their care 1.1.1 We will implement primary care initiatives to reduce acute hospital presentations that could have been prevented with earlier intervention 1.1.2 We will streamline Emergency Department processes to reduce the time to be seen in the Emergency Department by: – improving the management of clinical short stay patients – matching staffing to demand profile – improving work practices and processes – implementing the Adult Emergency Department Service Excellence Programme 1.1.3 We will streamline and improve the process of referral to inpatient specialties and admission to the inpatient ward or discharge by: – improving handover and transfer processes to inpatient	Patients will spend less time waiting for: – treatment in emergency departments – discharge from emergency departments once treatment is complete – transfer to an inpatient bed where patients require admission Patients will be given their date of discharge and informed of discharge plans early in their inpatient stay Patients' length of stay will be right for their care	**95% of patients will be admitted, discharged, or transferred from an emergency department within 6 hours** Increased use of Primary options for acute care (see primary care section 8.0) 95% of Adult Emergency Department patients are discharged from Emergency Department within 6 hours 100% of patients requiring inpatient referral are referred to an inpatient specialty within 3 hours Patient satisfaction with time to be seen is improved 100% of patients referred to an inpatient specialty will be seen within 60 minutes 100% of patients are transferred from the Emergency Department once an inpatient bed is allocated within 30

We take action	To deliver for communities and patients	As measured by
wards including Admission and Planning Unit – improving bed management practices and communication – implementing bed status at a glance		minutes
1.1.4 We will reduce length of stay by: – more effective weekend discharging (e.g. nurse facilitated discharges, physiotherapy facilitated discharges, weekend medical ward rounds) – improving inpatient team communication & discharge planning by implementing Daily rapid rounds – improving patient and family communication on care and discharge plan – implementing flex beds to respond to variation in demand – increasing the accuracy of estimated discharge dates – improving elective patient scheduling – improving transition lounge use – implementing the General Medicine Service Excellence programme		Length of stay reduction in the General Medicine by 10% Length of stay reduction in Orthopaedics by 5% Length of stay reduction in General Surgery by 10%
All these actions will be supported by the valuing patient time campaign and senior leader involvement		

2.0 Reduced Wait times: Improved Access to Elective Surgery

We take action	To deliver for communities and patients	As measured by
2. We will deliver elective surgical volumes that improve the intervention rates for the Auckland DHB population and support our IDF DHBs while reducing waiting times	Patients will have increased access to elective surgery Reduced waiting times Reduced unnecessary clinic appointments Reduced cancellations Improved access/choice for outpatient clinics	**Auckland District Health Board will deliver 11,950 elective surgical discharges in 2011-12 for the Auckland DHB population** **No patients waiting longer than 6 months from referral to First Specialist Assessment** **No patients waiting longer then 6 months from their First Specialist Assessment to procedure**

We take action	To deliver for communities and patients	As measured by
2.1.1 We will increase surgical and inpatient bed capacity through: – Opening 3 additional theatres at Greenlane Clinical Centre – Increasing overnight bed capacity at Greenlane Clinical Centre from 17 to 30	Reduced in-clinic wait time, movement, and re-work	
2.1.2 We will improve our productivity and throughput in existing operating rooms through elective service productivity initiatives including: – implementing the productive operating room theatre programme in 4 services – implementing service excellence programmes in Cardiac, General Surgery and Orthopaedics – implementing project solutions from Surgical Performance Improvement Programme e.g. improving session start time compliance, reducing cancellations, productive lists		Reduced late notice changes to lists in Orthopaedics, Cardiac, General Surgery by 50% Increased session start time compliance for ORL, General Surgery and Orthopaedics to 90% Reduced session cancellations by Operating Room driven reasons – level 8 and 4 by 50%, by service: Orthopaedics, Cardiac, General Surgery by 50%
2.13 We will improve our patient preparation and experience by redesigning our preadmission processes		One triaging process is in place across all services by December
2.1.4 We will improve our outpatient efficiency and patient experience through development of a productive clinic programme and pilot this in the Orthopaedic outpatient clinics		Patient satisfaction with clinic opening hours and available appointments
2.1.5 We will reduce waiting time for patients for First Specialist Assessment and Elective Surgery through improved outpatient and surgical planning and scheduling		Patients not waiting longer than 6 months for access to services
2.1.6 Implement a production planning process by service area		Updated production plans within 15 days of month end Actions to address variation within 15 days of end of month

3.0 Shorter Waits for Cancer Treatment- Radiation Therapy

We take action	To deliver for communities and patients	As measured by
3.1 Fully implement the Radiation Therapy Strategic plan for the sustainable delivery of radiation therapy to the Northern region population to ensure that all patients needing radiation therapy receive it within 4 weeks of their first specialist radiation oncology assessment	All patients eligible for radiation therapy receive this with the recommended timeline which reflects appropriate clinical practice	**100% of patients in categories A, B and C who are eligible and referred for radiation therapy treatment wait for no more than 4 weeks to start treatment once a decision to treat is made**
3.1.1 Establish a service delivery model aligned with the recommendations outlined in the Radiation Therapy Strategic Plan	Patients wait less time for treatment after their first specialist assessment	Ministry of Health targets will be implemented in 2012-13. In 2011-12 we will measure the percentage of patients who: – Receive an FSA within 4 weeks of referral – Commence treatment within 4 weeks of decision to treat The data will be used to inform service improvements to deliver to this target

4.0 Increased Immunisation

We take action	To deliver for communities and patients	As measured by
4.1 Meet immunisation targets, locally and regionally 4.4.1 Ensure immunisation data integrity, with general practice level reporting and monitoring maintained and referral processes to Outreach Immunisations Services streamlined – Ensure immunisation data integrity, with general practice level reporting and monitoring maintained and referral processes to Outreach Immunisation Services (OIS) streamlined – Targeted training provided for practice nurses and receptionists to ensure data quality is maintained and effective practice level systems are established – Practices pre-call all enrolled children according to schedule with automatic referral to OIS by the NIR team at a defined shorter interval once a child is overdue, inclusive of enrolled and not enrolled children	Two year olds are immunised against disease Better health and independence for children Children enrolled with a primary care provider	**Achieve a regional immunisation target of 95% of all 2 year olds fully immunised by July 2012** Northern Region target = 95% Auckland DHB target: – Total = increase from 89% to 95% – Māori = 95% – Pacific = 95% Immunisation cover measured via the National Immunisation Register Reduced rates of vaccine-preventable disease

We take action	To deliver for communities and patients	As measured by
4.4.2 Provide outreach services in the home and community for under-immunised children at key milestone ages, particularly targeting Maori, Pacific and other high risk children	Improved access and vaccination delivery for under-immunised Maori, Pacific and other high risk children at key milestone ages	Reduced inequity in immunisation rates, particularly for Maori children
4.4.3 Coordination of activities – National Immunisation Register Administrators, Outreach Immunisation services and PHO Immunisation Coordinators adopt a coordinated team approach to identifying unimmunised children and ensure appropriate immunisations are provided – Linkages between Plunket, other Well Child Providers, Starship Children's Health, within and across PHOs and other agencies are formalised though MoUs to help locate families of under immunised children and facilitate engagement with primary care and other immunisation services		Systems are in place for sharing data and for engaging with families not currently enrolled in a PHO
4.4.4 Implement the Auckland Social Sector Leaders Group Operational Opportunities Project to engage other sectors in activities to raise awareness about immunisation amongst their client groups		Ministries of Education and Social Development, and Housing NZ and Corrections each have nominated immunisation champions who are actively engaged in the project
4.4.5 Minimise decline rates by contacting, every 6 months, all families who have declined to establish whether a decline is still intended		
4.4.6 Work collaboratively to develop and implement a communications plan for Auckland DHBs to promote the importance of immunisation as a means of protecting children, whanau and the community		
4.4.7 Work with regional DHB colleagues to share information on effective strategies and to undertake joint initiatives where appropriate, specifically to improve access to immunisation services		

5.0 Better Help for Smokers to Quit

We take action	To deliver for communities and patients	As measured by
5.1 All smokers admitted to hospital will be offered brief advice and interventions to help them quit	Advice and help to quit smoking Nicotine replacement therapy and cessation programmes that increase the chance of a quit attempt being successful Review and improve training on the ABC of smoking cessation and quit card provision in hospital so that all eligible patients are provided with quit advice Patient referred to quit services, as appropriate	**95% of hospitalised smokers given help to quit via brief advice and intervention** Measure for Auckland DHB increases from 74% to 95%
5.1.1 Implement and improve on data collection and monitoring system so services can manage their progress towards meeting the target		100% of actions to help smokers are accurately recorded
5.1.2 Review training on the ABC of smoking cessation and quit card provision		Number of Auckland DHB staff that have completed ABC training = 500 Increased usage of Nicotine Replacement Therapy products No. of referrals to smoking cessation services
5.1.3 Enhance clinical engagement by creating a clinical steering group, implementing a research programme and monitoring & publishing performance by speciality	Increased clinical leadership and coordination of smoking cessation advice and intervention	League tables of performance in place and sent to clinical directors
5.2 90 percent of primary care enrolled patients will be provided with advice and help to quit by July 2012		90% of primary care enrolled patients will be provided with advice and help to quit by July 2012
5.2.1 Work with primary care so that all smokers enrolled with a General Practice will be given help to quit via brief advice and intervention	More and better trained GPs and Practise Nurses in the ABC of smoking cessation	
5.2.2 Assist with Implementation and improvements of data collection and monitoring systems in primary care so PHOs can manage progress towards meeting the target		League tables on PHO performance are in place and being used by PHOs to improve performance

6.0 Better Management of Diabetes and Cardiovascular Disease

We take action	To deliver for communities and patients	As measured by
6.1 Meet national targets for diabetes and cardiovascular disease	More people have their CVD risk assessed and identified early for interventions	**90% of the eligible adult population have had their cardiovascular disease risk assessed in the last 5 years**
	More annual diabetes checks for people with diabetes	**60%of people with diabetes attend free annual checks (60% for all ethnicities)**
	People get help in the community to manage their diabetes	**77% of people with diabetes have satisfactory or better diabetes management (Maori 72%, Pacific 72%, Other 80%, Indian 80%)**
6.1.1 Evaluate 2 community-based cardiac rehabilitation programmes		Evaluation results available and informing next steps for community based Cardiac rehabilitation programme
6.1.2 Report on care planning for people screened who either have diabetes or a risk assessment >15%	People with diabetes get better services including retinal screening	55% of people screened with risk >15% will have a management plan by June 2012
		80% of people screened with Diabetes will have a management plan by June 2012
6.1.3 Quality improvement coordinators support primary care to identify people who are diabetic and have not received their review – expand the use of diabetes registries – audit tool for primary healthcare	Better population overview of diabetic patients	50% of primary care practices have a diabetes registry by June 2012 A population audit tool available for all primary care practices by December 2011
6.1.4 Implement a community retinal screening service		Achieve year one retinal screening target in the Northern Region Health Plan (to be determined by Dec 2011)
6.1.5 Raise PHO awareness re Diabetes Get Checked programme for diabetic patients - practices encouraged to keep Get Checked in high awareness		Percent of people who have had their annual review will have an HbA1c <8% (Maori, Pacific, Other, Total %)
6.1.6 Develop core competencies for diabetes self management courses with supported self-management specifically for Maori and other high needs groups	All diabetes self management courses reviewed according to the core competencies	Self management competencies agreed by Dec 2011 5 new self management course leaders trained by June 2012
6.1.7 Strengthen self management via links to wider lifestyle activities e.g. green prescription	Self management courses that meet the needs of Maori patients	A minimum of two refresher courses for those who have completed a course delivered by June 2012

We take action	To deliver for communities and patients	As measured by
6.1.8 Boost workforce development for self-management skill development	Self management courses that meet the needs of Pacific patients	

7.0 Clinical Leadership

We take action	To deliver for communities and patients	As measured by
7.1 We will improve the capability of our clinical leaders	Skilled and accountable clinical leadership with clear delegated authority and active involvement in organisational and service decision making	**"In Good Hands" top 10% of DHB performance**
7.1.1 Continue to implement the clinical leadership model for level 2 and 3		All Level 2 Director appointments completed by Feb 2012 Level 3 Clinical Director review completed by Dec 2011
7.1.2 Develop and implement a comprehensive leadership programme for clinical leaders and senior managers		100% of Level 2 & 3 Maori and Pacific leaders attend the leadership development programme 60% of Level 2 & Level 3 leaders participate in leadership development
7.1.3 Support the development of, and provide leadership to, implement regional/national multidisciplinary clinical networks, inclusive of whole of sector participation		
7.1.4 Develop and implement Auckland DHB Healthcare Excellence Framework		
7.1.5 Develop a talent identification and development programme for future clinical leaders		90% of senior leaders participate in talent reviews 50% of talent with development plans

8.0 Services Closer to Home (see Appendix 3 for detail about the primary care business cases)

We take action regionally	To deliver for communities and patients	As measured by
8.1 Progress our "Locality Approach" to align healthcare planning and service delivery within Auckland Council Local Board areas This approach will develop a greater understanding of health need at a local community level which in turn will allow better targeted delivery and development of health services and support the shifting of appropriate hospital based services closer to the communities that use them Locality planning and service delivery are key enablers toward the development of a truly integrated 'mergent'[2] healthcare system	Partnership with local communities including deliberate strategies to connect with local populations in a continuous rather than episodic way Improved patient experience through integrated health service planning and delivery across the whole spectrum of care Enhanced local government engagement through structured links with elected Local Boards An intersectoral approach with other government and non-government agencies who have an influence on health and its broader determinants Improved decision making through better use of available data	Model of Locality Planning and Funding adopted in a minimum of three localities (Maungakiekie-Tamaki, Puketapapa and Whau) by 30 June 2012 Approach phasing: 1. Engage with the Ministry-funded Consortia to ensure development of the necessary network architecture to support the establishment of Integrated Family Health Centres (IFHCs) that progress the overall approach from July 2011 2. Local Health Network pilot developed in West Auckland by 30 December 2011 3. Local health need assessments and local health improvement plans completed for the three identified localities by 30 June 2012 4. Learning from the West Auckland Local Health Network pilot informs the development of additional networks as part of the Locality Model in Northern, Central and Eastern Auckland Suburbs by 30 June 2012 5. Connections with other social sector agencies that have a strong influence on health outcomes e.g. Auckland Council and Ministry of Social Development are formalised by 30 December 2011
8.2 Work with DHB-provided services to identify those that could be better delivered closer to where people live At Auckland DHB, this will be facilitated through the developing	Health care services are integrated, accessible and responsive to patients' health needs. Health care services delivered in community	Locality planning and activity, including devolution of services is explicit in Auckland DHB Healthcare Service Group plans Transfer and integration of agreed DHB services with Whanau

[2] 'Mergent' healthcare is a new term that extends the concept of integrated care and describes an increasing blurring of the boundaries between traditional silos of health planning and delivery

We take action regionally	To deliver for communities and patients	As measured by
Healthcare Service Groups Healthcare Service Groups, with their focus on the entire patient journey and care continuum, are key to enabling the shift of appropriate hospital based services closer to the communities identified through the locality approach (8.1) At Waitemata DHB, this will be facilitated through direct engagement of hospital provider arm services	locations closer to patients' homes.	House (Henderson Whanau Ora Centre) Planning for the transfer and integration of agreed DHB services within the New Lynn Integrated Family Health Centre and other IFHCs as they are developed
8.3 Review Auckland and Waitemata's primary mental health needs and current service delivery	An equitable and accessible stepped care approach for mild to moderate mental health needs Identification of gaps in current patient pathways and identify ways to address these Improved primary care response to mental health issues will prevent acute events An opportunity to feedback on current service design and improve future service delivery to ensure it is better, sooner, more convenient healthcare	Completion of review of primary mental health services for Waitemata and Auckland DHB service users in collaboration with Primary Care Organisations and consumers by 31 December 2011 Development of a revised service model that addresses equitability and access issues identified by April 2012
8.4 Support the establishment of an Auckland Regional After Hours Network (ARAHN) Work with the primary care led Auckland After Hours Alliance to implement a comprehensive after hours network	Better, more equitable access to an integrated after-hours primary health care service for the Auckland population An integrated after-hours service that is representative of multiple service providers across the system, e.g. Triage & Disposition, St John, GP, Accident & Medical, Emergency Departments and supports the patient's medical home as the main provider of care and coordination Has a focus on the reduction of inequalities by ensuring more affordable, standard co-payments across the network for high needs	Implement an agreed Auckland Regional After Hours Network as determined through the primary care led process Phased implementation from 1 September 2011 Fully implemented by 30 June 2012

We take action regionally	To deliver for communities and patients	As measured by
	patients	
8.5 In conjunction with our regional DHB and primary care partners, explore opportunities to better integrate existing sources of data to facilitate common understanding of health and healthcare activity across the continuum of care This work would seek to pull together existing proposals to work more regionally with data, such as proposals arising from the Northern Region Health Plan and Regional IS Plan One possibility for early consideration is how the establishment of an Auckland DHB-Waitemata DHB 'Data Action Unit' could contribute to regional developments	Increased robustness of data to contribute to informed decisions on management and planning of both community and hospital services Accessible health information that is: – Shared more evenly and openly – Observed easily by all in the sector, when relevant – Produced more regularly and in real time – Guarded securely	Work with our regional partners to investigate and scope options for improved integration of existing data sources, October 2011 Depending on the outcome of the scoping exercise, business cases for implementation of any Auckland DHB and Waitemata DHB components developed by 31 December 2011
8.6 Continue implementation of the following GAIHN led Auckland Regional projects that deliver the better, sooner, more convenient primary care policy: • **Minor Surgery** • **Clinical Pathways** • **Access to Diagnostics – Radiology** • **Primary Options for Acute Care**	Faster referral and treatment times Reduced waiting times for services Services provided more conveniently and closer to home for patients Regionally consistent processes Better integration and working together to improve services for patients	**Minor Surgery** 1,200 procedures for people requiring minor skin lesion surgery in the community (Counties Manukau DHB 400, Waitemata DHB 500, Auckland DHB 300) by 30 June 2012 Implement GP opinion survey by 30 September 2011 Implement two patient satisfaction surveys during 2011-12 (by December 2011 and June 2012) Investigate purchasing dermoscopy services to improve efficacy for pigmented lesions by end of December 2011 Investigate widening the scope of the regional project to include other minor procedures, completed by March 2012 to inform 2012-13 planning **Clinical Pathways** Evaluate the 2 pathways implemented in 2010-11 by December 2011, update as necessary. Implement the 4 pathways developed in 2010-11 by July 2012 Develop a further 5 clinical pathways by July 2012

We take action regionally	To deliver for communities and patients	As measured by
		Investigate electronic solutions and complete a business case for preferred options by March 2012 **Access to Diagnostics-Radiology** The rate of referrals that do not meet the clinical triage criteria from GPs to radiology are less than or equal to 20% by the end of June 2012 (currently up to 35%) Through engagement with primary and secondary clinicians, agree an appropriate target for waiting times for routine imaging and report performance against the target for Metro Auckland DHBs from January 2012 The volume of DHB-funded GP-requested diagnostic radiology procedures performed in the community will increase by 10% across the Metro Auckland DHBs, on 2010/11 volumes by 30 June 2012 **Primary Options for Acute Care** 33% increase over 10/11 target volumes (to 20,000 across the Metro Auckland DHBs) by 30 June 2012 Expanded range of 'options' included in service by 30 June 2012
8.7 To actively support the three Better Sooner More Convenient Business Cases in Auckland: • **Alliance Health +** • **Greater Auckland Integrated Health; Network (GAIHN)** • **National Hauora Coalition** 'Active support' from DHBs includes: – Participation in business case-led projects' working and steering groups, including facilitating the participation and engagement of hospital based clinicians – Secondment and/or funding of human resources to	Better, Sooner, More Convenient healthcare services including: – Faster referral and treatment times – Reduced waiting times for services – Services provided more conveniently and closer to home for patients – Regionally consistent processes – Better integration and working together to improve services for patients	The business cases will be measured against achievement of their own deliverables – see Appendix 3 for detail about the 3 business cases As partners in the business cases, DHBs are committed to supporting them to achieve their stated objectives subject to appropriate agreements being reached between all parties

We take action regionally	To deliver for communities and patients	As measured by
support the work programme within DHB budget parameters – Participation in governance and planning groups as required including a commitment of appropriately senior DHB personnel to the Alliance Leadership Teams – Collaborative sharing of necessary resources and data – Participation constructively and in good faith. This includes supporting Provider Arm clinical leadership to attend and support required working groups to ensure efficient implementation of agreed initiatives		

9.0 Health of Older People

We take action	To deliver for communities and patients	As measured by
9.1 Participate in the development of a Regional Clinical Network for Health of Older People	Better alignment of service planning and provision	Clinical network established by 1 August 2011 Clinical leader, project manager and network appointed by 1 August 2011 Develop network implementation plan by 1 December 2011 Formalise relationships with social agencies with agreed objectives by 31 December 2011
9.2 Finalise the Home Based Support Services redesign by implementing flexible packages of funding informed by case mix and measured by InteRAI	Services closer to home that are more flexible and responsive Home care delivered flexibly within the locality and tailored to client's needs and goals	Contracts in place using case mix methodology Community Care Access Centre has results from the trial introduction of the Community Health Assessment Tool Review and evaluate the model by 1 October 2011 to inform regional discussion 100% of community services using InteRAI by 30 June 2012 Consistent regional InteRAI monitoring in place by 30 June 2012

We take action	To deliver for communities and patients	As measured by
9.3 Better understand and manage the drivers that result in admissions to Aged Residential Care	Appropriate, timely intervention which is consistent across the region	Review rates of access to Aged Residential Care by age across the region by 31 March 2012 Agree consistent access criteria to Aged Residential Care by 31 June 2012 Continue to enhance Home Support Services further to the work that has already been done to introduce new model to offset demand for admissions to Aged Residential Care
9.4 Promote ageing in place in line with the regional and national strategy	Greater access to services and a more responsive approach to changing need	Review and evaluate capacity for respite care by 1 March 2012
Monitor the delivery as well as outcomes of the respite care fund	Ensures the appropriate and effective use of the respite fund	Increase access to respite care by 20% by 31 June 2012 2011-12 target for respite care to 480 clients (from base of 180) Provide each of the new Enhanced Home Based Support Agencies with a fund for their population (circa $100,00 each) to enable them to provide flexible in home respite for clients who meet the agreed respite criteria
9.5 Better support of Older Adults with cognitive decline/Mental Health issues through improved management and coordination of services	More protection for people vulnerable to abuse	Clinical care pathways developed for clients with Dementia, 1 January 2012 Pathway implemented by 30 June 2012 100% of Auckland DHB Home Based Support Services agencies have Memorandum of Understandings in place with Alzheimers Auckland
9.6 Better understand the drivers that impact on avoidable acute demand for people over 65, particularly those coming from Residential Care	Greater range of appropriate services Fewer inappropriate admissions to secondary care	Models of specialist support to Aged Residential Care reviewed for the region with standardised approach as appropriate Implement medication review across community services, July 2012 Consistent methodology and target agreed across the region for falls prevention, by 1 August 2011

We take action	To deliver for communities and patients	As measured by
		Programme to reduce falls implemented across Older People's Health and Aged Residential Care, by 1 February 2012 Consistent methodology and targets agreed across the region for treatment of pressure areas, by 1 August 2011 Programme to reduce pressure areas across Older People's Health and Aged Residential Care implemented, by 1 February 2012 Inappropriate admissions to acute care reduced in line with regionally agreed baseline and target
9.7 Participate in workforce modelling and development across the sector	Well trained and responsive workforce	Identify and scope workforce shortages regionally, by 1 December 2011

10.0 Children and Young People

We take action	To deliver for communities and patients	As measured by
10.1 Improve the oral health of children and adolescents		**National oral health targets achieved for children and adolescents in Auckland DHB area**
10.1.1 New and refurbished school dental clinics: Avondale Intermediate; Royal Oak Intermediate; Wesley Intermediate; Blockhouse Bay Intermediate; Ponsonby Intermediate; Orakei Primary; Mt Roskill Primary (proposed site); Auckland Normal Intermediate	Better oral health services and outcomes for children and adolescents, with reduced inequities	All new and refurbished school dental clinics (8) to be completed by 30 June 2012 and operational by October 2013
10.1.2 Provide 2 new diagnostic mobile vans	Dental clinics with longer opening hours More dental therapists and dental assistants More oral health education	Total of 2 new diagnostic mobile vans – delivered in April and May 2012 – operational by 30 June 2012
10.1.3 Improve access for pre-school aged children using pre-school coordinators	More pre-schoolers are enrolled and seen by the service	3 pre-school coordinators in place

<table>
<tr><th>We take action</th><th>To deliver for communities and patients</th><th>As measured by</th></tr>
<tr><td>Coordinators visit pre-school centres to increase enrolments, do pre-school examinations, and provide fluoride treatment and full treatment options at a nearby dental clinic. High needs pre-school centres are visited every 6 months</td><td></td><td>Improved enrolment and preventative oral health care for pre-schoolers
<table><tr><th>Ethnicity</th><th>Total Enrolment Numbers at February 2011</th><th>Anticipated Enrolment Numbers by 30 June 2012</th></tr><tr><td>Maori</td><td>2195</td><td>3000</td></tr><tr><td>Pacific Island</td><td>3749</td><td>4600</td></tr><tr><td>Other</td><td>12485</td><td>14163</td></tr><tr><td>Total</td><td>18429</td><td>21763</td></tr></table></td></tr>
<tr><td>10.1.4 Increase early enrolment in dental care with a focus on Maori and Pacific populations</td><td>Maori and Pacific children get dental care in the settings appropriate for them</td><td>Pre-school coordinators are in place to access pre-school centres, kohanga reo and language nests</td></tr>
<tr><td>10.1.5 Increase adolescent utilisation</td><td>More adolescents using the contracted dentists for free dental care</td><td>Increase adolescent utilisation of dental services to 77% by 30 June 2012</td></tr>
<tr><td>10.2 Headss (Home, Education, Activities, Drugs, Sexuality, and Suicide/Depression) Assessments are offered to all Year 9 high school students, Alternative Education and Teen Parent students within school based health services funded by Auckland DHB</td><td>Unmet health needs identified for all decile 1-3 schools, Alternative Education Centre, Teen Parent Unit and students from some other schools

Young people get the services they need so they can participate fully in secondary school or alternative education</td><td>In the 2011 calendar year, 85% of eligible students receive a Headss Assessment increasing to 90% in the 2012 calendar year</td></tr>
<tr><td>10.3 The new Well Child Framework is implemented successfully across Auckland DHB Well Child providers</td><td>All children 0-5 years and their families are able to access a universal screening and support programme to improve and protect children’s health

Parents receive support in the areas of parent/child bonding; post natal depression; child development; and family violence

Better linkages between maternity providers and Well Child nurses

Reduced inequities in health status</td><td>Revised reporting requirements met

95% of Auckland DHB children are enrolled with a Well Child provider at age 1 year</td></tr>
</table>

We take action	To deliver for communities and patients	As measured by
10.4 Create a seamless transition from the Lead Maternity Carer to Well Child and Primary Care providers	Improved engagement with primary care at the beginning of a child's life so health issues are identified early and interventions are put in place	The three parties agree a process to collect the data required to support ongoing improvements
10.5 Every 4 year old is offered a B4 School Check through the B4SC Alliance	Unmet health needs are identified. Children access services needed so they are ready to participate fully in primary school	80% of all children, including 80% of high needs children, receive a B4 School Check and access necessary intervention services before starting school
10.6 Work with the Ministry of Education and schools to develop a model for identifying unmet health need in students who have been suspended or stood down and to better link them with health and other intervention services	Identifies young people at risk of poor health and other outcomes. Improves delivery of appropriate health interventions	Concept developed and service design issues is agreed

11.0 Regionalisation through Collaboration

We take action	To deliver for communities and patients	As measured by
11.1 Health Services Plan		
11.1.1 First Do No Harm		
11.1.1.1 Work regionally on a campaign to improve patient safety focussed initially on reducing harm from falls causing harm, pressure injuries, central line acquired bacteraemia, transfer of care, patient identification and specific high risk medication events	Improved patient safety Improved quality of care	20% reduction in falls and pressure injuries Reduce central line acquired bacteraemia by 40% in one clinical unit
11.1.1.2 Implement a consistent tool (IHI global trigger tool) to measure progress		Global trigger tool data reported monthly
11.1.2 Life and Years		
11.1.2.1 Focus on regional key health improvement targets: CVD, Diabetes, Health of Older People and Cancer	Improved management of chronic conditions A whole of system, cross regional approach	Achievement of health targets for cardiovascular disease and diabetes
11.1.3 The informed patient	Improved patient and family experience and ensuring the right type and amount of care	Functional Advance Care Planning available for 150 patients in the Auckland DHB

We take action	To deliver for communities and patients	As measured by
11.1.3.1 Develop and implement Advance Care Planning	for all patients. Reduce the use of unnecessary admissions, tests and treatments in dying patients	
11.2 healthAlliance NZ Ltd		
11.2.1 We will achieve reduced back-office costs through standardisation and consolidation of regional systems and processes in the newly formed regional entity	More cost effective administrative functions	Business case target savings of $4.06M achieved across the region
11.3 Waitemata DHB/Auckland DHB		
11.3.1 The stronger bilateral opportunity offered by a shared chair and Maori board membership will allow us to optimise service planning and delivery across our two organisations	Improved patient experience	Services integrated where we've identified that service quality or costs can be improved

12.0 Reduced Inequities

We take action	To deliver for communities and patients	As measured by
12.1 Maori		Whanau Ora outcome measures established for the 3 business cases
12.1.1 Implement Whanau Ora outcome measures across 3 BSMC primary care business cases in the areas of long term conditions and child health	Pathways of care that improve health outcomes for Maori Maori patients have better coordinated care through the health system Simplified and transparent pathways for navigation	95% of 2 year olds fully immunised by July 2012 90% of smokers seeing a GP get quit advice 60% of Maori diabetic patients access free annual diabetes check by July 2012 90% of eligible Maori (men aged over 35 years and over and women aged 45 years and over) will be risk assessed for CVD 1% - 2.9% reduction in ASH rates for Maori (all age groups)
12.1.2 Work with primary care to develop 1 initiative to increase Maori enrolments with a PHO across all age groups		90% of Maori enrolled with a PHO
12.1.3 Develop a Toi Oranga Whanau Ora school based pilot		Toi Oranga Whanau Ora school-based pilot in 2 kohanga reo

We take action	To deliver for communities and patients	As measured by
initiative in 2 Auckland DHB kohanga reo and primary schools to create relationships between primary care providers and whanau ora providers and whanau		Improve Maori breastfeeding rates of 64% six weeks; 55% three months; 24% six months by July 2012 ASH rates remain below 64% for Maori (for children under the age of 5 years) 80% Maori children receive a B4 School Check and access necessary intervention services before starting school Increase preschool enrolments for dental services from 11% to 13% by 2012
12.1.4 Implement 2 collaborative initiatives within the diabetes and child Health Services Groups to improve Maori health outcomes		
12.1.5 Complete 1 initiative aimed at increasing the Maori clinical workforce in Auckland DHB	Improved quality of hospital care to Maori patients and whanau	Increase the Auckland DHB Maori clinical workforce
12.1.6 Work with Healthcare Service Group leadership groups to develop and implement goals and priorities to achieve Maori health gain improvement targets	Improve the quality of hospital care while improving productivity	Whanau Ora implementation within Auckland DHB's Healthcare Service Groups Maori health priorities included in all Healthcare Service Group business plans 95% of all hospitalised patients who are Maori are given brief advice to quit Complete an audit of Treaty of Waitangi principles Establish a community dialysis service by July 2012
12.1.7 Complete an ethnicity audit across the top 5 DRG areas for Maori health in Auckland DHB's inpatient services to ensure appropriate data capture processes		Ethnicity audit complete Ethnicity data re Maori utilisation of services correct
12.1.8 Implement the Iwi Based Solution for Maori mental health		Release an RFP for an Iwi Based Solution Increased support hours Increased respite services for Maori level 3 and 4

We take action	To deliver for communities and patients	As measured by
		Increase residential services for Maori level 3 and 4
12.1.9 Review and develop the Maori health and Tikanga content of the Auckland DHB health excellence framework		Health excellence tool developed Maori health excellence targets set for all Healthcare Service Groups
12.1.10 Implement the Iwi Based Solution for Maori mental health		The Iwi Based Solution for Maori mental health in place
12.1.11 Work with Renal Services and Maori primary care providers to design, devolve and deliver Adult Haemodialysis services in community settings	Kidney disease prevention, early intervention and chronic kidney disease management services closer to home and in appropriate settings	Refer to section 14.4
12.2 Pacific 12.2.1 Improve Healthcare Service Groups responsiveness to Pacific peoples with high health needs	Quality clinical care and Pacific best practice for all Pacific patients throughout hospital journey Reduce health inequalities	At least 1 Pacific Best Practice (PBP) workshop delivered to Auckland DHB staff within each Healthcare Service Group Evaluation and analysis of each completed workshop to identify any gaps or staff education needs Meet all requests for interpreter services for Pacific patients/families - 2 Tongan trained and qualified interpreters Promotion of Pacific health needs through Pasefika Week Celebration at Auckland DHB
12.2.2 Self management education for Pacific peoples living with long term conditions in the community	Increased health literacy through appropriate and effective education for Pacific peoples with long term conditions.	Hold 6 self management courses within HVAZ No. of Pacific people attending each course, and maintaining 80% attendance rates over 6 weeks with Healthy Village Action Zone course Evaluation and analysis of effectiveness of each course
12.2.3 Work with Renal Services and Pacific primary care providers to design, devolve and deliver Adult Haemodialysis services in community settings	Kidney disease prevention, early intervention and chronic kidney disease management services closer to home and in appropriate settings	Refer to section 14.4

We take action	To deliver for communities and patients	As measured by
12.2.4 Increase and retain Auckland DHB Pacific health workforce 12.2.4.1 HR policies that support Pacific recruitment and retention 12.2.4.2 Identify and support Pacific clinical leadership development within each Healthcare Service Group through engagement with our Auckland DHB Pacific workforce network	Increased recruitment and retention of Pacific peoples to ADHB workforce to better reflect the communities we care for.	Recruit and employ at least 2 Pacific New Grads per Nursing Entry To Practice (NETP) programme Increase to 8% the number of Pacific staff within Auckland DHB, nursing and medical workforce Activities implemented to actively increase the number of Pacific people on Auckland DHB workforce programmes (see 14.6) Auckland DHB Pacific network and Regional clinical Network established Activities implemented to identify, develop and support Pacific mental health leadership At least 2 Pacific regional (Auckland DHB, Counties Manukau DHB, Waitemata DHB) clinical network forums held
12.2.5 Increase Pacific antenatal attendance rates at Gestational Diabetes clinics and referral to Primary care services	Scope future project to Better, sooner, more convenient approach for high need Pacific vulnerable pregnant women	Increase screening rates for diabetes for Pacific women in pregnancy No. of referrals between Auckland DHB women's health with Pacific primary care services, and Whanau ora Pacific support Provider
12.2.6 Pacific Smoking Cessation Service	Appropriate Pacific smoking cessation programmes with Pacific-trained facilitators Help Pacific smokers to quit or reduce smoking	All participants will be supported on an ongoing basis and to make quit attempts with subsequent 3 month follow up
12.3 Culturally and linguistically diverse populations 12.3.1 Cultural competency training for staff working in primary and secondary health services	Staff who are culturally competent Mainstream responses across diverse populations	15% of clinical staff complete at least 2 of the 4 on-line modules
12.3.2 Increase the uptake of the Primary Health Interpreting Pilot	Better access to primary care because interpreters are available to help Better care in the community	100% of people who do not speak English can access an interpreter in a general practice

13.0 Disabled People

We take action	To deliver for communities and patients	As measured by
13.1 Prioritise recommendations from the audit report on accessibility of Auckland DHB services and facilities	Visible action of the national disability strategy Plans reflect the perspective of people with disabilities	Recommendations are prioritised, agreed and implemented in conjunction with the Disability Support Advisory Committee The prioritisation will be complete by the end of July and agreed in August 2011. There will be short, medium and long term implementation objectives over 3 years
13.2 Improve opportunities for disabled people within the health workforce in conjunction with the national mainstream programme	Disabled people enjoy equitable access to employment	At least one staff member is recruited to a service in partnership with Mainstream by 30 December 2011

14.0 Healthcare Excellence

We take action	To deliver for communities and patients	As measured by
14.1 Engaged Workforce/Culture 14.1.1 Develop a culture of patient safety, open disclosure, timely and empathetic communication with respect for patients and families at all times commencing with the following initiatives: – implement a coaching framework – leadership walk around programme – open disclosure training for level 2 & 3 leaders 14.1.2 Develop our clinical leaders and managers to be more effective at developing culture and taking action within our management operating system 14.1.3 Introduce a staff engagement survey tool	Improved service delivery	Voluntary Staff turnover rates less then 10% Application referrals from staff average> 50 per month Coaching framework implemented by March 2012 60% of Leaders participate in the Leadership development programme Baseline Engagement Survey Results established
14.2 Community and patient focus 14.2.1 We will continue to implement our consumer and community engagement framework by establishing a web-	More in-depth consumer engagement in quality improvement and service planning Stronger and on-going voice for consumers	Performance criteria are identified and benchmarked to enable subsequent performance measurement of consumer participation in DHB decision-making, for example:

We take action	To deliver for communities and patients	As measured by
based community panel and developing a cohort of consumer representatives	in decision making	– Community panel delivers timely, relevant feedback around identified issues – Consumer representatives are actively involved in 2 service improvement initiatives
14.2.2 Bereavement management framework is developed and implemented	Improved patient and family experience in death and dying	Framework for bereavement management is developed and implemented by April 2012
14.2.3 We will improve our risk mitigation management and the length of time for completion of an Root Cause Analysis arising from a serious or sentinel adverse event		Initiation of risk mitigation factors (Controls) for all serious or sentinel adverse event 100% of the time within 2 hours 100% Completion of preliminary case review within 4 days for all SAC 1 incidents
14.2.4 We will establish an integrated complaints framework that defines what high quality complaints management is, with accountability and responsibility at health services level, supported by a central administration structure and the consumer engagement strategy 14.2.5 We will improve our feedback process to reduce the length of time to complaint resolution	Greater openness and transparency when adverse events occur Increased direct clinical contact and timeliness in response to complaints	Customer satisfaction survey regarding complaints and adverse events processes by Healthcare Service Group Increase in face-to-face resolution of serious complaints from 5% to 90% Resolution time is less than 20 working days for more than 80% of all complaints and median resolution time is less than 15 working days A baseline for a quality of complaints management process is established
14.3 Improved processes-new models of care		
14.3.1 Performance improvement activity 14.3.1.1 Increasing the number of wards in Adults, Children's, Cancer, Cardiothoracic and Mental Health services using Releasing Time to Care	Improved ward productivity with staff spending more time with patients and families	Number of wards increases from 26 to 41 increasing direct care time by 7%
14.3.1.2 Implement the productive operating theatre programme/lean improvement programmes	Reduces the time that patients are waiting for cardiothoracic surgery Improve the patient experience while improving productivity	Reduced no. of theatre sessions that start late, finish early, or are cancelled (see also section 2.0) Maintain 28 day unplanned acute readmission rates at the current rate or lower
14.3.1.3 Performance improvement actions focused on-radiology, cardiac surgery, research, general medicine, general	Improved processes which eliminate	A balanced scorecard and defined improvement actions are

We take action	To deliver for communities and patients	As measured by
surgery, adult emergency department, operating rooms	unnecessary outpatient follow-ups	in place for each service
14.3.2 Mental health 14.3.2.1 Develop new services for: – Young People – Adults – Older Adults – Maori	Increased range of services available	Alternative to admission service for young people fully operational by 1 October 2011 Alternative to admission service for Adults fully operational by 1 October 2011 New service(s) for Older Adults are scoped and contracted for by 1 July 2012 The iwi based solution incorporating new service(s) for Maori fully operational by 1 July 2012
14.3.2.2 Increase awareness of mental health services for high risk minority groups – Muslim – Lesbian, Gay, Bi-sexual and Transgender (LGBT) – Pacific	High risk minority groups are aware of opportunities to engage with appropriate services	Mental Health training to local Imams delivered by 1 July 2012 Following the completion of the LGBT project (31 December 2011) at least 1 recommendation implemented by 1 July '12 Pacific suicide prevention fono held by 31 December 2011
14.3.2.3 Increase responsiveness to those with a coexisting problem (CEP)	Services are responsive to those with a coexisting problem	All new and varied contracts have a clause requiring services to be responsive to those with a coexisting problem At least 10% of Auckland DHB Mental Health clinical staff will access Ministry of Health CEP-provided assessment and formulation workshops by June 2012
14.3.2.4 Scope low secure rehabilitation service for high and complex needs		Low secure rehabilitation option scoped by September 2011 and if appropriate implemented by December 2012
14.3.3 Cancer 14.3.3.1 Implement medical oncology service improvements	Patients referred for specialist assessment get assessed in accordance with national criteria	Access levels within 2 weeks, 4 weeks and 6 weeks of Referral to First Specialist Appointment and Decision to Treat to Commencement of Treatment
14.3.3.2 Continue regional lung tumour stream development and service improvement in care pathways	Improved early diagnosis and management of lung cancer	60% of primary lung cancer patients are discussed at Thoracic Multidisciplinary meeting within 28 days of referral 50% of patients have surgery as 1st treatment within 14 days of being discussed at Thoracic Multidisciplinary meeting

We take action	To deliver for communities and patients	As measured by
		50% of patients have FSA for radiation oncology within 14 days of being discussed at Thoracic Multidisciplinary meeting, when radiotherapy is first treatment 50% of patients have FSA for medical oncology within 14 days of Thoracic Multidisciplinary meeting, when chemotherapy is first treatment
14.3.3.3 Continue regional bowel tumour stream development and service improvement in care pathways	Improved early diagnosis and management of pre malignant bowel conditions Improved early diagnosis and management of bowel cancer	Median time from the date patient is placed on the waitlist for colonoscopy to date of colonoscopy procedure by priority category 1-4
14.3.3.4 Establish a regional mechanism to strengthen the delivery capacity of palliative care providers	Timely and equitable access to funded palliative care services for patients across all care settings Better care for patients into the future A formal plan to address priority areas requiring improvement	Demonstrate the introduction of 24/7 specialist palliative care telephone advice to generalist providers in the hospital and community by 30 March 2012 Establish baseline of care telephone advise utilisation and set improvement goal by April 2012 Reporting mechanism developed for number and percentage of people who die with a care pathway in place at the end of life in hospital, hospice, home and residential care, by April 2012
14.3.3.5 Participate in the establishment of a Haematology Clinical network		Haematology Network established and beginning to identify service priorities and develop appropriate implementation plan by December 2011
14.4 Renal Services 14.4.1 Renal Services will work in partnership with primary care to design, devolve, and deliver Adult Haemodialysis (AH) for patients who are unable to home dialyse	Adult Haemodialysis Units in community settings, situated in localities with the largest clusters of current and projected numbers of adult patients requiring dialysis provides Haemodialysis services closer to people's homes	Two 12 – 25 station, community located Adult Haemodialysis Units established by 30 June 2012
14.4.2 The new model of care will integrate kidney disease prevention, early intervention, and chronic kidney disease management services	Community located Adult Haemodialysis Units provide better integration of primary and secondary care services for dialysing patients, and in the surrounding	New model of care agreed and implemented as each community located Adult Haemodialysis Unit becomes operational

We take action	To deliver for communities and patients	As measured by
	communities for at risk populations	
14.5 Rehabilitation Services 14.5.1 Agree the principles which will inform a new service design for rehabilitation services 14.5.2 Pulmonary Rehabilitation 14.5.2.1 Improve the outcomes for people with COPD 14.5.2.2 Increase the numbers of COPD patients being referred to and undertaking Pulmonary Rehabilitation	Improved responsiveness to clients with a rehabilitation need People with COPD have access to pulmonary rehabilitation services at locations closer to where they live Increased patient involvement in their ongoing self management	Agree scope of project across Auckland DHB/Waitemata DHB by 30 August 2011 Agree new model of care incorporating inpatient and community services by 30 June 2012 Provide a minimum of 5 community pulmonary rehabilitation courses by April 2012
14.6 Workforce new models Participate in Health Workforce NZ initiatives 14.6.1 Implement and evaluate the Registered Nurse First Surgical Assistant pilot 14.6.2 Pilot the diabetes nurse prescribing role 14.6.3 Implement the Auckland regional training hub – Implement Compulsory Career Plans for House Officers in 2011 as a pilot and evaluate – Implement regionally consistent education and training resources with ADHB represented through our Director of Clinical Education and Medical Education Unit Manager – Nursing will focus on coordinated development of extended scopes of practice to complement medical workforce development – Allied health will focus on a project designed to ensure a common understanding of existing post graduate education investment	A highly trained, well supported workforce Provides education and training that supports the medical workforce across the region House Officers will access career planning resources (web, written and trained SMOs) and will plan their runs for the following training year in May and June annually	4 Nurses Pilot and pilot evaluation completed by end March 2012 Pilot and evaluation completed by end March 2012 3 Diabetes nurses prescribing by May 2012 Career Plans Evaluation undertaken in September, final process in place from November 2011 90% of RMOs have Career Plans in place (receiving HWNZ funding) Evidence that the training workforce is more engaged in decisions relating to training Decreased number of trainees taking longer than expected to vocationally register

We take action	To deliver for communities and patients	As measured by
14.6.4 Expand Workforce Development for Maori and Pacific – Rangatahi programme – Auckland DHB Cadet programme – New Graduate Nurse programme into primary health/ community care – A+ Trust / Auckland DHB Scholarship programmes 14.6.5 Implement Career Pathways Programmes for Maori and Pacific: – Pathways to Health Careers (P2HC) as part of Tamaki Transformation work – Year 2 of the Nga Manukura o Apopo (Maori nursing & midwifery) programme		Maori and Pacific workforce show increased numbers / FTE by ethnicity
14.7 Performance management system 14.7.1 We will continue to implement a knowledge management and measurement system with an accountability approach to allow clinical and managerial leaders to make effective and timely decisions		
14.7.2 Implement the resilience improvement plan Phase 4 delivered on time and complete critical system upgrades	Better informed clinical decision making Improved clinical workflow	Number of unplanned system outages reduced to <5 per month Tier 1 system availability is >99.80%
14.7.3 Improve corporate information management	Robust IT systems with the required capacity	Public Records Act compliance improved in line with agreed work programme Enterprise Content Management System available to users Clinical Records System, Picture Archiving System, and Finance Management System upgraded
14.7.4 Reduce NHI duplicates		NHI duplicates <6%
14.7.5 Implement regional eReferrals and shared care information systems		eReferrals: phase 1 completed, phase 2 approved and started Shared Care Planning: phase 1 completed, phase 2 approved and started

We take action	To deliver for communities and patients	As measured by
14. 8 Healthcare Excellence Framework 14.8.1 We will conduct a baseline organisation evaluation against the Healthcare excellence criteria. As part of the evaluation process we will ensure that tikanga and Treaty of Waitangi principles are integral in determining our performance benchmarks		An evaluation is complete by June 2012 and the standard for excellence incorporates tikanga and Treaty of Waitangi principles

15.0 Living within our Means

We take action	To deliver for communities and patients	As measured by
15.1 Deliver a breakeven budget through focused volume and funding management	Correct volume of affordable elective services and treated within waiting time guidelines	Year end 2011-12 breakeven budgeted result achieved
15.1.1 Disciplined volume and funding risk management for the Auckland DHB Population	Highly disciplined management of public funds and services	
15.1.1.1. Elective volume and funding: Implementing a patient and operations planning process to ensure early visibility of variances to plan and corrective action		Updated production plans within 15 days of month end Actions to address variation within 15 days of month end
15.1.1.2 Acute volumes: Manage volume and cost risk through productivity improvement and BSMC initiatives		Monthly reporting of effectiveness of mitigation initiatives Volume and efficacy management by clinical leaders within budget parameters
15.1.2 Disciplined volume and funding risk management for IDFs. Continue IDF relationship management process with key IDF customers		Signed agreements with main IDF customers by July 1, 2012 Monthly reviews held with action plans agreed and in place with IDF customers for top and bottom 3 variances within 15 days of month end
15.2 Deliver a breakeven budget through focussed Provider cost management **15.2.1 People Cost**		Year end 2011-12 breakeven budgeted result achieved Deliver to budget assumptions

We take action	To deliver for communities and patients	As measured by
15.2.1.1 Disciplined management of FTE numbers, annual leave, sick leave and CME		Monthly reporting including monitoring effectiveness of mitigation initiatives
15.2.1.2 Managing Administration and Management staff numbers within the cap		
15.2.1.3 Manage and review impact of MECA Settlements		
15.2.2 Productivity		
15.2.2.1 Deliver productivity & quality gains by Healthcare Service Group (including initiatives to deliver increased electives and shorter stays in Emergency Dept)		Delivery of appropriate volumes from available resources
15.2.3 Clinical Supply Costs		
15.2.3.1 Utilisation of new and existing clinical supplies monitored for clinical effectiveness		No new unapproved treatments introduced
15.2.3.2 Leverage national and local procurement		Health Benefits Ltd savings achieved of $4M
15.2.4 Strengthen collaboration within and outside the organisation		
15.2.4.1 Clinical: Review service models for cancer and cardiac and integrate with private sector		Cost growth within parameters to allow demand growth
15.2.4.2 Non Clinical: Implement new Health Alliance organisation		Reduced costs delivered to Auckland DHB and northern region
15.2.4.3 National contracts to transfer to NHB		Value of resources transferred not impacting Auckland DHB
15.2.4.4 Waitemata and Auckland DHBs integrate services where there is service quality and cost opportunities		Savings to the bottom line
15.3 Deliver a breakeven budget through focussed Funder cost management		Year end 2011-12 breakeven budgeted result achieved
15.3.1 Manage contracts within budget , with particular focus on Community Pharmacy, Laboratories, Rest homes		Community pharmacy, laboratory and Health of Older People services managed to 1% of budget, or mitigation strategies in place
15.3.2 Ensure BSMC + 3 Business cases deliver improved		Initiatives implemented as detailed in this module's section

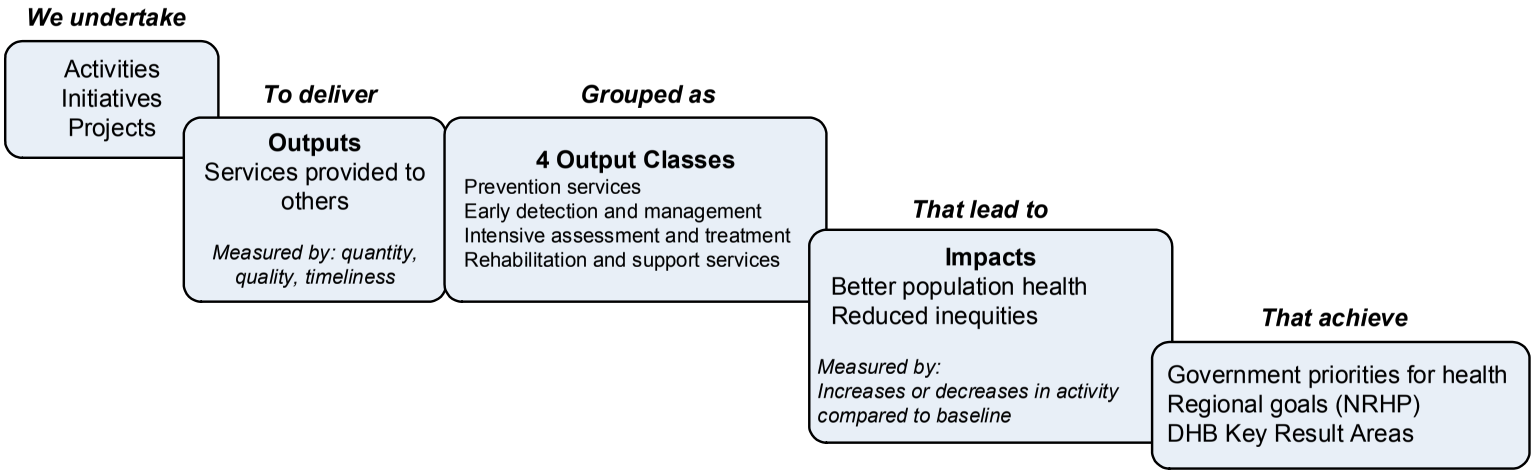
We take action	To deliver for communities and patients	As measured by
processes and realise the planned benefit from defined projects		8.0
15.3.3 NHB new payment system eliminates transaction error		System implemented as required by NHB
15.3.4 Oral Health capital expenditure programme within budget		Oral health capital expenditure managed to budget

Module 4: Forecast Service Performance

The Forecast Statement of Service Performance identifies our outputs, the measures of these, and annual targets for 3 years from 2011 to 2014. 2009-10 actual performance is used as our baseline for the targets. Any significant shifts are described as footnotes on the outputs tables.

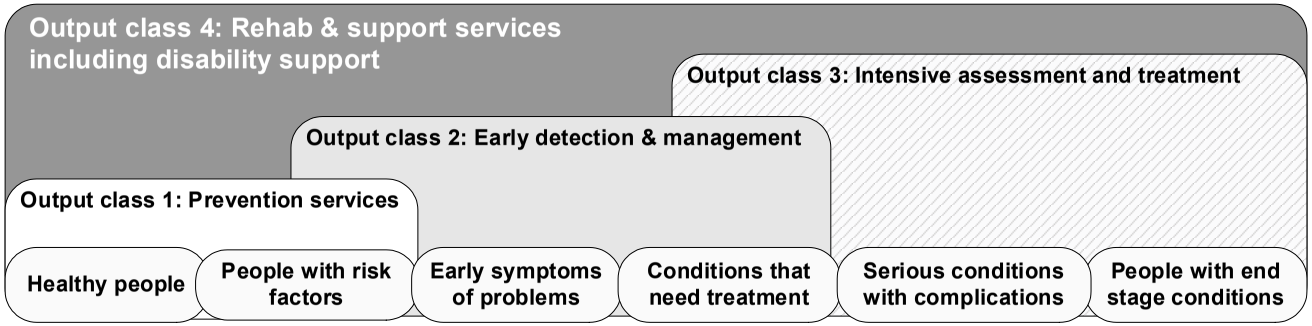
This material fulfils the terms in section 139 of the Crown Entities Act 2004 and sections 39 and 42 of the NZ Public Health and Disability Act 2000. The Auditor General will audit the accuracy and reasonableness of DHB achievements when they are recorded in our Annual Report.

The intervention logic that underpins this Statement of Intent



Auckland DHB believes the outputs and measures as presented in this section provide a reasonable representation of the full range of services provided by our organisation. The measures included relate to the quantity, the quality, or the timeliness of services; or some combination of these three. For the purpose of this Statement of Forecast Service Performance, activities are grouped by four output classes:

1. Prevention Services
2. Early Detection and Management
3. Intensive Assessment and Treatment
4. Rehabilitation and Support



4.1 Output Class 1: Prevention Services

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td>Alcohol and tobacco regulatory activities

Monitoring compliance with smoke free and alcohol sales legislation</td><td>Monitoring and enforcement of liquor and tobacco premises to ensure compliance with regulations</td><td>No. of compliance checks for liquor and tobacco premises conducted

No. of alcohol licenses applications reported on

Number of controlled purchases operations

Number of Smokefree complaints closed</td><td>Reduced breaches of the Smokefree and alcohol legislation

Reduced number of sales to minors</td><td>Reduction in alcohol and tobacco related harm

Improved health outcomes</td></tr>
<tr><td>Improve access to smoking cessation services

Identify and work with those groups of people who have a high proportion of smokers

Train clinical staff to deliver smoke-free interventions</td><td>Smoking cessation advice and support delivered by health professionals in secondary and primary care</td><td>450 pregnant women or their families enrolled in smoking cessation programmes

95% of eligible hospitalised smokers provided with advice and help to quit by July 2012
<table>
<tr><th></th><th>Baseline</th><th>By July 2012 (and outyears)</th></tr>
<tr><td>Maori</td><td>75%</td><td>95% (95%, 95%)</td></tr>
<tr><td>Pacific</td><td>73%</td><td>95% (95%, 95%)</td></tr>
<tr><td>Other</td><td>74%</td><td>95% (95%, 95%)</td></tr>
<tr><td>total</td><td>74%</td><td>95% (95%, 95%)</td></tr>
</table></td><td>Lower prevalence of smoking-related conditions

Reduced proportion of smokers in the population

A long term reduction in smoking related cancers</td><td>Increasing smokefree environments and people

Reduction in smoking-related chronic diseases

Reduced admissions to hospital by children with a smoking related admission</td></tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td></td><td></td><td>90% of eligible patients attending primary care get advice and help to quit by July 2012

Quality: 100% of actions to help smokers are accurately recorded</td><td></td><td></td></tr>
<tr><td>Encourage and ensure local providers are promoting, protecting and supporting breastfeeding

Work with populations that have lower breastfeeding rates</td><td>Breastfeeding services are providing appropriate and accessible information and advice to mothers and their families</td><td>Breastfeeding rates: six weeks:<table><tr><th></th><th>Baseline</th><th>By July 2012 (and 2 outyears)</th></tr><tr><td>Maori</td><td>62%</td><td>64% (65%, 66%)</td></tr><tr><td>Pacific</td><td>56%</td><td>60% (62%, 66%)</td></tr><tr><td>Other</td><td>72%</td><td>74% (75%, 76%)</td></tr><tr><td>Total</td><td>68%</td><td>74% (75%, 76%)</td></tr></table>Breastfeeding rates: three months:<table><tr><th></th><th>Baseline</th><th>By July 2012 (and 2 outyears)</th></tr><tr><td>Maori</td><td>53%</td><td>55% (56%, 57%)</td></tr><tr><td>Pacific</td><td>48%</td><td>50% (52%, 55%)</td></tr><tr><td>Other</td><td>63%</td><td>65% (64%, 65%)</td></tr><tr><td>Total</td><td>59%</td><td>61% (62%, 63%)</td></tr></table>Breastfeeding rates: six months:<table><tr><th></th><th>Baseline</th><th>By July 2012</th></tr><tr><td>Maori</td><td>22%</td><td>24% (25%, 26%)</td></tr><tr><td>Pacific</td><td>17%</td><td>20% (21%, 22%)</td></tr><tr><td>Other</td><td>30%</td><td>32% (33%, 34%)</td></tr><tr><td>Total</td><td>27%</td><td>29% (30%, 31%)</td></tr></table>900 women enrolled with the Community Breastfeeding Service</td><td>Healthy children

Reduced likelihood of acquiring long term conditions later in life</td><td>Healthier children

Improved women’s health

Whanau Ora aspirations achieved for Mama and Pepi</td></tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td></td><td></td><td>2 Well Child providers achieve Baby Friendly Community Initiative accreditation</td><td></td><td></td></tr>
<tr><td>Fund providers to deliver vaccinations against:
– Measles
– Diphtheria
– Pertussis
– Mumps
– Influenza
– Tetanus
– Human papillomavirus
– Rubella</td><td>Primary care services performing immunisations

Immunisation services (through general practice, outreach immunisation services, schools and other community settings)

Girls immunised against human papillomavirus</td><td>Immunisation: 2 year olds fully vaccinated
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>89%</td><td>95% (95%, 95%)</td></tr></table>Immunisation: Year 7 children vaccinated DTap-IPV
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>51%</td><td>60% (60%, 60%)</td></tr></table>Immunisation: Yr 8 girls vaccinated for Human Papillomavirus, dose 3
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>54%</td><td>60% (60%, 60%)</td></tr></table></td><td>Hospital admissions for vaccine preventable disease (including cervical cancer and pre-cancerous lesions) in children and adults are reduced

Reduced incidence and mortality from vaccine preventable diseases among children and adults

Reduced incidence of cervical cytological abnormalities</td><td>Healthier children and adults: lower incidence of vaccine-preventable disease and cervical cancer in females</td></tr>
<tr><td>Fund and provide services for the metro Auckland region that promote, improve, maintain and restore good oral health:
– Health promotion activities for children & adolescents living in disadvantaged areas. particularly Maori and Pacific peoples
– Oral health examination education provided to preschool children & their parents
– Oral health examination and education for school age children and adolescents
– Oral health examination and treatment services</td><td>Oral Health education

Oral examinations and treatment among preschool children, school children, and adolescents

Fluoridation advocacy outputs (varied)</td><td>Enrolment rates for children <5yrs and low income adults

Enrolment and preventative oral health care for pre-schoolers
<table><tr><td>Baseline no.</td><td>2011-12 anticipated (& outyears)</td></tr><tr><td>18429</td><td>21763 (22,000; 25,000)</td></tr></table>Total no. of permanent teeth of year 8 children, DMFT:
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>0.92</td><td>0.80 (0.75, 0.70)</td></tr></table>Percent caries free at five years
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>65%</td><td>69% (70%, 71%)</td></tr></table>Quality:
– Annual clinical audit report</td><td>Better oral health for children and adolescents

Caries among children and adolescents is prevented

Caries Is detected early and treated before major damage to teeth occurs

Improvement of overall oral health with the reduction of inequalities among different ethnic groups

More adolescents are engaged with oral health services</td><td>Improved health

Greater equity

Living within our means

Confidence and trust in the health system</td></tr>
</table>

We undertake initiatives/activities	And deliver outputs	Outputs measured by	That lead to health impacts	And contribute to outcomes
for low income adults – Advocacy of community water fluoridation		– Complaints & incidents – Arrears rates – Waiting time		

4.2 Output Class 2: Early Detection and Management

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr>
<td>Subsidise primary care services provided by GPs, including programmes like diabetes “Get Checked”, CVD Risk assessment and management, Primary Options etc

Subsidise primary care work provided by Primary Health Organisations including diabetes coordination, services to improve access for high risk groups

Subsidise region-wide work to improve the performance of primary care through the GAIHN</td>
<td>Enrolment PHO affiliated general practice teams

Nurse and GP consultations for enrolled population:
– diagnose & treat acute and long term conditions
– refer to secondary care services when appropriate
– social support and advice to families

Prevention work:
– immunization
– advice and help to quit smoking</td>
<td>Diabetes Get Checked
<table>
<tr><th></th><th>Baseline</th><th>By July 2012 (and outyears)</th></tr>
<tr><td>Maori</td><td>55%</td><td>60% (62%, 64%)</td></tr>
<tr><td>Pacific</td><td>55%</td><td>60% (62%, 64%)</td></tr>
<tr><td>Other</td><td>58%</td><td>60% (62%, 64%)</td></tr>
<tr><td>Total</td><td>57%</td><td>60% (62%, 64%)</td></tr>
</table>
Satisfactory Diabetes Management
<table>
<tr><th></th><th>Baseline</th><th>By July 2012 (and 2 outyears)</th></tr>
<tr><td>Maori</td><td>72%</td><td>72% (74%, 76%)</td></tr>
<tr><td>Pacific</td><td>72%</td><td>72% (74%, 76%)</td></tr>
<tr><td>Other</td><td>83%</td><td>80% (82%, 84%)</td></tr>
<tr><td>Total</td><td>84%</td><td>77% (79%, 81%)</td></tr>
</table>
Ethnic-specific primary care enrolment rates

Cervical screening coverage

Quality:
– Proportion of practices with ACC accreditation
– Proportion of practices with cornerstone accreditation</td>
<td>Prevention of illness

Management and cure of treatable conditions

Proportion of diabetic detected and managed appropriately (national health target)

Maintenance of functional independence

Minimising unnecessary use of high cost secondary care

Incidence rate (and inequalities in) invasive cervical cancer</td>
<td>Improved health

Greater equity

Living within our means

Confidence and trust in the health system</td>
</tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr>
<td>Purchase and monitor community referred testing and diagnostic services including:
– laboratory tests
– radiological services for cardiology, neurology, audiology, endocrinology, respiratory
– pacemaker physiology tests
– ante-natal screening</td>
<td>Community referred laboratory tests and other diagnostics services.</td>
<td>Number laboratory tests

Number radiological images

% of routine laboratory tests (by volume) completed and communicated to referring practitioners within 48 hours from time of receipt:

% of urgent tests completed and communicated within either 3 hours of receipt of the sample at the lab or the timeframe determined by the Laboratory Clinical Board for that particular type of test

Fasting blood lipid tests per head of population at risk (CVD risk assessment health target measure)
<table>
<tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>79%</td><td>90% (90%, 90%)</td></tr>
</table>
Quality:
– Value of diagnostic testing purchased
– Unit cost of tests benchmarked against that paid by other DHBs
– Accreditation and annual audit reports for community laboratory services
– Proportion of tests that are repeated</td>
<td>Prompt diagnosis of acute and chronic conditions

Reduced demand on specialist outpatient

Ratio of diagnostic laboratory tests in relation to need e.g. no. of Hba1c tests per estimated prevalence of diabetes, benchmarked against other DHBs</td>
<td>Improved health

Greater equity

Living within our means

Confidence and trust in the health system</td>
</tr>
<tr>
<td>Subsidise the community based provision of prescribed pharmaceuticals</td>
<td>Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations</td>
<td>Total value of subsidy provided

Proportion of dispensing expenditures relative to expenditure on pharmaceuticals

No. of prescriptions subsidised

No. of individuals receiving subsidised prescriptions

Quality: Proportion of prescriptions with a valid NHI number
<table>
<tr><td>Baseline (Dec 10)</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>96%</td><td>98% (99%, 99%)</td></tr>
</table>
</td>
<td>Good access to effective pharmaceutical treatments

Lower per capita out of pocket and total expenditure on pharmaceuticals

Prescription rates in relation to need (patients with NMDS recorded diagnoses) for sentinel conditions (e.g. hypertension and diabetes) benchmarked against other DHBs

Achieving all targets in the PHO Performance Programme</td>
<td>Improved health

Greater equity

Living within our means

Confidence and trust in the health system</td>
</tr>
</table>

4.3 Output Class 3: Intensive Assessment and Treatment

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr>
<td>Timely access to acute care and appropriate timely discharge

Improve Emergency Department capacity and services to meet needs

Timely transfer to appropriate services from Emergency Department service

Ensure good access to support services in the community or primary care level to support patient recovery following an acute event</td>
<td>Acute inpatient services

Emergency Department services</td>
<td>95% of patients admitted, discharged, or transferred from ED within 6 hours
<table>
<tr><td>Baseline 2008/09</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>76%</td><td>95% (96%, 97%)</td></tr>
</table>
4 week max. waiting times for chemotherapy treatment (from the decision to treat)
<table>
<tr><td>Baseline 2008/09</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>100%</td><td>100% (100%, 100%)</td></tr>
</table>
Acute inpatient length of stay
<table>
<tr><td>Baseline 2008/09</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>4.25</td><td>4.00 days (3.92, 3.90)</td></tr>
</table>
Acute readmissions to hospital, standardised
<table>
<tr><td>Baseline 2008/09</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>11.5%</td><td>9.95% (9.50%, 9.00%)</td></tr>
</table>
Quality: 100% of patients requiring inpatient referral are referred to an inpatient specialty within 3 hours</td>
<td>Effective and prompt resolution of medical and surgical emergencies and acute conditions

Reduced mortality

Positive patient experience re wait times

Standardised mortality rate for acute myocardial infarction within 30 days of admission benchmarked against rates in other DHBs (Target: be among the 4 DHBs with the lowest mortality rate).

Reduced number of acute re-admissions</td>
<td>Improved health

Greater equity

Living within our means

Citizen confidence and trust in the health system</td>
</tr>
<tr>
<td>Providing safe, accessible maternity, obstetric and neonatal care services</td>
<td>Non-specialist antenatal and obstetric consultations

Amniocentesis

Maternity inpatient, outpatient care & follow-up

Labour and delivery</td>
<td>Percent term elective Caesarean performed at <39 wks
<table>
<tr><td>Baseline 2009</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>58%</td><td>35% (33%, 30%)</td></tr>
</table>
Breastfeeding rate on discharge excluding NICU admissions
<table>
<tr><td>Baseline 2009</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>81.6%</td><td>> = 80% (> = 82%,> = 85%)</td></tr>
</table></td>
<td>Live births

Safe childbirth

Healthy baby

Healthy mother

Improved maternal mental health</td>
<td>Improved population health

Reduced inequities

Trusted health system

Living within our means</td>
</tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td></td><td>services

Postnatal inpatient, primary & outpatient care

Specialist neo-natal care</td><td>Quality:
– Reduced maternal deaths (baseline 8, 2009)
– Reduced admissions to NICU (baseline 10.4%, 2009)</td><td></td><td></td></tr>
<tr><td>Provide and purchase elective inpatient and outpatient services</td><td>Elective inpatient services

Elective outpatient services</td><td>Compliance with national health target for surgical discharges
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>11,147</td><td>11,950 (TBA, TBA)</td></tr></table>Total QALYs gained from the 5 Ministry of Health selected procedures, and

Calculated as the number of procedures multiplied by QALYs per procedures:
– Hip (primary) = 0.85
– Hip (revision) = 0.15c
– Knee = 0.8c
– Cataract (1st eye) = 1.25
– Cataract (both eyes) = 2.1d
– Cataract (2nd eye) = 0.92d
– CABG = 1.3
– PCI = 1.64
Increasing overnight bed capacity (Greenlane)
<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>17</td><td>30 (30, 30)</td></tr></table>Quality:
– Patient satisfaction
– Readmission rates
– Post-operative hospital-acquired bacteraemia rates
– ESPI compliance</td><td>Restoration of functional independence

Longer life

Positive patient experience</td><td>Improved health

Greater equity

Living within our means

Citizen confidence and trust in the health system</td></tr>
<tr><td>Provide an inpatient specialist geriatric</td><td>Sub-acute inpatient</td><td>Standardised discharge rate</td><td>Maximising functional independence and health-related</td><td>Improved health</td></tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td>evaluation, management and rehabilitation service for older adults</td><td>care of older adults</td><td>Standardised bed-day rate

Proportion of patients newly-institutionalised (benchmark: other DHBs)

Proportion of patients admitted acutely with CVA who are seen in a Stroke Unit

Assessment Treatment and Rehabilitation (Inpatient) waiting time (average days per patient)</td><td>quality of life in older adults

The proportion of patients with an improvement in function between Assessment Treatment and Rehabilitation admission and discharge as measured by a standard test of function</td><td>Greater equity

Living within our means

Citizen confidence and trust in the health system</td></tr>
<tr><td>Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services</td><td>A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health and Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands.

Services comprise
– acute & Intensive services
– community based clinical treatment & therapy services
– services to promote resilience, recovery and connectedness</td><td>Access Rates for total and specific population groups (proportion of the population using Mental Health and Addiction services in the last year)
<table><tr><td></td><td>2011-12 (and 2 outyears)</td></tr><tr><td>Age 0-19</td><td>3.19% (as advised by MoH)</td></tr><tr><td>Age 20-64</td><td>3.30% (as advised by MoH)</td></tr><tr><td>Age 65 +</td><td>3.58% (as advised by MoH)</td></tr><tr><td>Extra no. of clients</td><td>= 909 (as advised)</td></tr></table>Measured for:
– Total / child & youth / adult / older adult population (all ethnicities)
– Maori (total / adult / child & youth / older adult)
– Pacific (total / adult / child & youth / older adult)
Quality:
– 95% of long term clients (in the above population groups) have a Relapse Prevention Plan
– alcohol and drug service waiting times and waiting list report (Policy Priority 8)</td><td>Prompt recovery from acute mental illness

Prevention of mental illness relapses

Social integration and improved quality of life

Mental health access rate is a proxy measure for determining the impact of our mental health services on improving the quality of life for people with severe mental illness or who have issues with alcohol or drug addiction</td><td>Improved health

Greater equity

Living within our means

Citizen confidence and trust in the health system</td></tr>
</table>

4.4 Output Class 4: Rehabilitation and Support Services

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr>
<td>Use the InterRAI tool to ensure people who need home based support services receive them in a timely way

Give those with complex needs priority access to home support services

Provide timely access to assessment, treatment and support services for older people with complex health problems</td>
<td>Home based support services</td>
<td>Total number of home-based support service hours
<table>
<tr><td>Baseline</td><td>2011-12 (and outyears)</td></tr>
<tr><td>6,000</td><td>650,000 (annual increase per annum)</td></tr>
</table>
No. of people 85 yrs and over supported in their own homes with complex packages of care
<table>
<tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>600</td><td>660 (10% cumulative)</td></tr>
</table>
Number of low-level clients self managing on support packages with input from key workers
<table>
<tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>150</td><td>175 (180, 190)</td></tr>
</table>
Number of reassessments for clients receiving home-based support services
<table>
<tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>7900</td><td>9480 (20% increase cumulative)</td></tr>
</table>
Increase access to respite care
<table>
<tr><td></td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>180</td><td>480 (review and adjust to meet needs)</td></tr>
</table>
% of people over 65 years presenting to Emergency Dept
<table>
<tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr>
<tr><td>25%</td><td>24% (23%, 22%)</td></tr>
</table>
</td>
<td>Older people with complex needs remain living in their home for longer

Fewer people over 65 years presenting to Emergency Department

Fewer people over 75 years admitted to hospital as a result of a fall

Respite care available and improving quality of life</td>
<td>People living as independently as possible

Good quality of life for people who depend on support services</td>
</tr>
</table>

<table>
<tr><th>We undertake initiatives/activities</th><th>And deliver outputs</th><th>Outputs measured by</th><th>That lead to health impacts</th><th>And contribute to outcomes</th></tr>
<tr><td></td><td></td><td>Percentage of people over 75 years of age hospitalised for falls<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>None</td><td>Targets agreed by August 2011</td></tr></table>Quality: Number of complaints received about home based support service providers</td><td></td><td></td></tr>
<tr><td>Access to subsidised beds is based on assessed need

Contracted beds are available for people requiring long-term residential care</td><td>Residential care services</td><td>Quality of life for those in Aged Residential Care: no. of complaints<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>55</td><td>25% reduction (cumulative)</td></tr></table>Quality: 100% of residential care services meet required certification standards</td><td>Quality of Life for those dependent on aged residential care

Better management of chronic conditions for those aged 65 years and over

Reduced no. of falls and presentations to ED</td><td>Support and protections for the ageing population</td></tr>
<tr><td>Contract with hospice services to provide care

Provide specialist palliative care services

Fund home-based palliative care</td><td>Specialist end of life care</td><td>Number of people who die in their place of choice

Number of palliative clients accessing primary care under the subsidised DHB/PHO partnership<table><tr><td>Baseline</td><td>2011-12 (and 2 outyears)</td></tr><tr><td>150</td><td>Maintain at 150</td></tr></table></td><td>Community based assistance to patients at end of life and families

Reduced demand on hospitals</td><td>Improve quality of life remaining for patients through information, co-ordination and communication</td></tr>
</table>

Module 5: Stewardship

5.1 Funder Interests

The District Health Board contracts non government organisations (NGOs) to provide health and disability support services for people living in the Auckland DHB area. Some services are covered by a regional contract and therefore cover people living across the wider Auckland region e.g. some general practice work, supported accommodation for people with severe mental illness.

Summary of other services (non-hospital)

Type of provider	No. of providers	Total value of service $000	No. of beds
Community laboratory (Lab Tests Auckland Ltd and Diagnostic Med Lab Ltd)	2	78,671	Not applicable
Dental	70 (total facilities 72)	5,951	Not applicable
Health of older people services - residential care	65 (total facilities 76)	94,913	4,157 contracted beds (at 31 January 2011)
Health of older people services (inter district flows)		$8,781	
Health of older persons services -non-residential care	13	9,905	Not applicable
Home-based support	5	21,338	
Maori health services	2	1,088	Not applicable
Mental health services (residential services include: Eating Disorders, Residential Rehabilitation and Respite)	30	27,383	242 contracted beds (among other services purchased)
Mental health (inter district flows)		18,172	
Mental health services - alcohol and other drug services	6	8,887	180 contracted beds (among other services purchased)
Pacific health services	3	989	Not applicable
Primary Care Organisation (PCO)	1	1,690	Not applicable
Personal health (includes PHO Non-Head Agreement services and National Travel Assistance)	14	18,668	Not applicable
Personal health services (inter district flows)		75,007	
Pharmacy	124	120,486	Not applicable
Pharmacy (wholesalers)	3	6,000	Not applicable
Primary Healthcare Organisations (PHOs) capitated services (includes Alliance Health Plus Trust, contracted for services delivered to the ADHB population via Counties Manukau DHB)	4	159,692	Not applicable
Women's and children's health services	19	7,245	Not applicable
		664,868	**Total beds in the community = 4,579**

Primary Healthcare

Government health policy is focused on Better, Sooner, More Convenient Primary Health Care across New Zealand. This is being advanced in our district through three primary healthcare entities which cover over 95% of the metro Auckland population:

Greater Auckland Integrated Health Network (GAIHN): Covers over one million enrolled people across 6 PHOs within the greater Auckland region

Alliance Health+: A PHO created by the merger of the 3 Pacific-led PHOs across Counties Manukau DHB and Auckland DHB

National Hauora Coalition: A North Island consortium of PHOs with a focus on Whānau Ora

The push for Better, Sooner, More Convenient Primary Care across our northern region is significantly changing the current way that the metro Auckland Primary Health Organisations (PHOs) work. The three primary care business cases underway will integrate these PHOs across the DHB boundaries. It means the closer involvement of other services for patients and it increases clinical leadership in health decision making.

Primary Health Organisation (PHO)	% Maori	% Pacific	% Other	Total no. enrolled	% of total	No. full-time Drs
Auckland PHO Limited	2,712	4,054	33,253	40,019	9%	55
	10%	7%	10%	9%		
Alliance Health Plus Trust	2,327	12,320	16,156	30,803	10%	24
	9%	21%	5%	7%		
ProCare Network Auckland Limited	11,663	24,204	225,471	261,338	69%	284
	43%	41%	67%	62%		
Te Hononga O Tamaki Me Hoturoa	6,020	8,039	35,486	49,545	1%	6
	22%	13%	11%	12%		
Enrolled outside but live within ADHB boundaries	**4,543**	**11,122**	**24,586**	**40,251**	**10%**	
Total enrolled population: Auckland DHB	**27,265**	**59,739**	**334,952**	**421,956**		**417**
Total ADHB Population 2011	**36,486**	**51,857**	**369,822**	**458,165**		
	75%	**115%**	**91%**	**92%**		
ADHB as the lead DHB						
Auckland PHO Limited	3,440	5,980	42,425	51,845	6%	
	4%	6%	7%	6%		
ProCare Network Auckland Limited	58,493	72,406	544,965	675,864	82%	
	73%	74%	85%	82%		
Te Hononga O Tamaki Me Hoturoa	17,814	19,154	55,073	92,041	11%	
	22%	20%	9%	11%		
	79,747	**97,540**	**642,463**	**819,750**	**100%**	
Total ADHB as the lead DHB	**10%**	**12%**	**78%**	**100%**		

5.2 Provider Interests

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

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

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

5.3 Organisational Health

Organisational values

Integrity Respect Innovation Effectiveness

Kia u ki te tika me te pono

Good Employer

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

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

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

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

This includes:

- Recruitment
- Pay, recognition and other rewards
- Career development
- Work conditions

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

Auckland DHB will:

- provide an organisational culture, with strong clinical leadership and accountability, where everyone is able to contribute to the way the organisation develops, improves and adapts to change
- ensure that employees maintain proper standards of integrity and conduct in accordance with Auckland DHB's "Values" and the State Services Commission "Code of Conduct"
- provide a healthy and safe workplace, equipment and conditions
- provide recruitment, selection and induction processes which recognise the employment requirements of women, men and persons with disabilities
- recognise the aims, aspirations and employment requirements of Maori people
- take measures to ensure that qualified Maori candidates are given every opportunity for employment and Auckland DHB may adopt special measures to ensure Maori representation and participation at Auckland DHB
- recognise the aims, aspirations and employment requirements of Pacific Island people
- take measures to ensure that qualified Pacific Island candidates are given every opportunity for employment and Auckland DHB may adopt special measures to ensure Pacific Island representation and participation at Auckland DHB
- recognise the aims, aspirations, cultural differences and employment requirements of people from other ethnic and minority groups
- provide opportunities for individual employee development and career advancement

Regional Workforce and Human Resource joint activity and initiatives

The four DHBs in the Northern Region align Human Resource activity to health policy and ministerial expectations of greater collaboration and sharing of resources across support services. Regional work covers Employment Relations, recruitment, Workforce Development, Learning and Development, Occupational Health and Safety, special projects, HR infrastructure and systems development, and shared services. The work programme covered below will ensure recruitment, learning, education and workforce plans are regionally aligned.

The Northern Regional Shared Services organisation	This organisation assists with planning and implementation of shared strategies and projects within this field. The move to common systems and organisational structures means the DHBs are better equipped to plan and manage the HR issues associated with a large and diverse workforce.
The Northern Region DHBs Human Resource Management Strategy 2009-2013	This strategy focuses on retaining talent within our region via enhanced recruitment and retention practice.
National Human Resource projects	Employment Relations experts contribute to HR national work projects: the SMO job sizing project, aligning remuneration to the MECA, and implementing regional remuneration relativity strategies.
Regional management of	The three metro DHBs employ 1,100 Resident Medical Officers (40% of the national

Resident Medical Officers (RMOs)	workforce). The Auckland Region DHBs own and operate the shared services organisation which facilitates Resident Medical Officer administration across the region. The company provides recruitment, allocation, rostering, daily operations, workforce development and general administration support. RMOs are allocated into training runs under the direction of professional College aligned Vocational Training Committees.
Physician Assistant role	The four Northern Region DHBs and the University of Auckland Faculty of Medical and Health Sciences are undertaking a pilot of the USA trained, medical model Physician Assistant role
Centres of learning	The Centre for Research and Innovation (Ko Awatere) and the Health Campus will enhance learning opportunities in technical and clinical training, leadership and management development and professional development.
Initiatives aimed at Maori and Pacific students	School-based programmes prepare Maori and Pacific young people for tertiary studies in health related courses and ongoing employment in the sector. Better health outcomes result from more Maori and Pacific students in education, in good jobs and earning higher incomes.

5.4 Building Capacity

Regional IS

To implement the National IT Plan 2010 and the Regional Information Strategy 2010 -2020, a large programme of work is required that will stretch many years. The Northern Region Information Systems Implementation Plan (NRISIP) outlines this programme of work for the next 3 to 5 years. Although projects in NRISIP have already been prioritised to some extent, the programme is still very ambitious. It is likely that due to the usual challenges around resourcing, complexity and governance the programme will need to be spread over a longer period of time.

The regional CMOs have agreed that the main clinical driver is to improve the continuity of care for patients in our region across primary, secondary and tertiary care through providing consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care. This is fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery which is being embedded throughout the Northern Region Health Plan.

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

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

The 2011 Minister's letter of expectations requires regional plans which focus on a small number of high priorities and regionalisation of IT platforms and IT support. The 16 February 2011 letter to DHB CEOs from the Chair of the DHB Information Group and from the Director of the National Health IT Board states that each DHB will need to significantly reduce the number of local health IT projects and focus on regional clinical projects. The letter states that replacing legacy applications must be a priority so that each region will have a common and standard regional IT platform.

The Chief Information Officers and Chief Medical Officers have identified a shortlist of key foundation projects which need to be planned, funded and implemented regionally and with some urgency:

- Single patient administration system
- Single Clinical Workstation
- Regional Clinical Data Repository
- Population Health Data
- IS Infrastructure Resilience

Other priorities

While the key foundation projects are critical to building a robust platform for ongoing regional information systems they will take a number of years to achieve. Regional project teams will be established over the next few months to plan these programmes of work and project the necessary funding for the coming years. These programmes of work should be the key focus for regional investment and activity and should be "protected" in local DHB capital and operational expenditure prioritisation processes.
Given the elapsed time before completion of these projects, some investment will also be possible and required in other regional projects that underpin the delivery of key clinical priorities in the short to medium term. Other regional priorities that have been identified include:

- E Referrals Phase 2
- E Discharges implemented to national standards
- E Medicines including e medicines reconciliation, community & hospital e prescribing
- Shared Care Plan Phase 2
- E Rostering
- Establishment of the northern region shared services organisation (Health Alliance) including network integration, single sign-on and single service desk
- Shared financial management and procurement systems
- IS support for Better Sooner More Convenient business case workstreams
- Implementation of a data action unit supplying patient information across the continuum of care

Annual Plan 2011-12 Proposed Regional IS Content

While the region will progress many other IT enabled business and clinical projects such as e referrals, shared care plan, e business, these 5 initiatives are prioritised in this Annual Plan because: they represent the priority foundations for single regional patient systems which will underpin shared care; as Annual Plan priorities they will have a focus they will not get elsewhere; they are consistent with and supportive of the national health IT plan.

The expectation is that the size and complexity of the two key regional IS processes noted in the section above is such that the most that can be achieved in FY11-12 is agreement on the common processes. Therefore the IT project will begin preparation in FY12-13, with implementation likely in FY13-14.

Co-operative developments

We will consult with the Minister, via the Ministry of Health, on any significant developments during the financial year that are not signalled in this plan.

Agreement and Arrangements

Section 24 of the New Zealand Public Health and Disability Act
The finalisation of this plan authorises and permits Auckland DHB to enter into co-operative agreements or arrangements implicitly or expressly required to achieve the strategic objectives and outcomes outlined in this plan or to deliver the services Auckland DHB is required by statute or contract with the Crown or any other party to deliver. The terms and conditions of those co-operative agreements or arrangements will be as Auckland DHB considers appropriate for the particular services contracted for in that service agreement.

Section 25 of the New Zealand Public Health and Disability Act
The finalisation of this plan authorises and permits Auckland DHB to enter into service agreements implicitly or expressly required to achieve the strategic objectives and outcomes outlined in this plan or to deliver the services Auckland DHB is required by statute or contract with the Crown or any other party to deliver. The terms and conditions of those service agreements will be as Auckland DHB considers appropriate for the particular services contracted for in that service agreement.

In this 2011-12 Annual Plan, Auckland DHB signals its intention to enter into collaborative agreements, including alliance contracts, with other organisations to implement local, regional, and national plans for the most effective and efficient delivery of health services or activities that are consistent with government strategies such as 'better, sooner, more convenient'. The following are some of the other specific reasons Auckland DHB may enter into co-operative agreements or arrangements:

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

Module 6: Service Configuration

Auckland DHB will follow the Service Change Protocols in the Operational Policy Framework and notify the National Health Board of any service change that may arise from any service reviews planned for the coming year.

Proposal notified as a service change or plans to review a service	NHB Response
Palliative care: shift in resources to better align our current practice to that which was outlined in the Auckland DHB palliative care strategy. It is also our intention to make District Nursing available 24 hours a day	Supported
Advance care planning – initially a pilot project involving several DHBs across the country to develop clinical training programmes and tools to help patients and clinicians co-design advanced care plans	Supported
Establishment of community-based pulmonary rehabilitation and primary care spirometry in the management of COPD	Supported
Enact the findings of our accessibility review. Involves checklists for all areas of the DHB to self-review, with prioritised activity around e.g. disability responsiveness training for new staff	Supported
Currently seeking approval to establish up to 2 community-based dialysis units for Auckland DHB population in conjunction with Integrated Family Health Centres	Supported
Surgical management of skin lesions in accredited primary care practices	Supported
Home Based Support Services: further devolution of services to community services including respite care and carer support. Devolve additional responsibility to the 4 Home Based Support Services providers by handing the carer support and respite budgets to them (currently managed centrally by the provider arm)	Supported
Health of older people: Phase three (final stage) of the community and home base support model will be fully implemented. The contracting method will change from the old hourly rate to a case weight price per client based on acuity, same as the hospital DRG system	Supported
Establish community-based diabetes retinal screening	Supported
After Hours services. Auckland DHB has participated in a regional after hours project to develop a sustainable solution to after hours service provision in the Auckland metro region. The solution will include establishing a core network of after-hours services for our shared populations that will increase access to more affordable, more equitable, after-hours urgent care It is likely that after-hours clinics will be reduced to 10 (from 8am – 10pm) across the Auckland metro region with each DHB having their own solution to over-night services (10pm – 8am)	Supported
Primary Options For Acute Care. Auckland DHB has participated in a regional process to look at primary options for acute care services. This service will increase the capacity and capability of primary healthcare to provide safe acute care in the community The service will coordinate and facilitate existing infrastructure, processes and resources in order to provide a range of alternatives (including defined packages of care) to an acute hospital presentation referral. A request for proposal process will also be undertaken	Supported
Transfer of surgical procedures currently performed at Auckland City Hospital to Greenlane Clinical Centre with new elective surgical capacity in place. Greater collaboration with and use of private surgical providers to perform outsourced elective procedures whilst further internal capacity and surgical performance improvements come on stream	Supported
Assessing the feasibility of introducing Deep Brain Stimulation for Tourettes Syndrome	Supported

Module 7: Production Planning

Production Planning (the price volume schedule)

2011-2012 planned outputs for Auckland DHB hospital and specialist service*

			Proposed volumes	
HSG	**Hospital specialist service**	**Unit of measure**	**Auckland population**	**For other populations**
Adult – surgical	General surgery	Attendance	13,147	3,109
		Contact	589	3
		Cost weighted discharge	8,452	2,603
		Procedure	419	
		Written plan of care	0	2
	Liver transplants	Assessment	0	78
		Attendance	377	624
		Procedure	0	49
		Programme	0	1
	Neurosurgery	Attendance	764	2,201
		Cost weighted discharge	1,513	3,795
		Procedure	1	
		Written plan of care	0	19
	Ophthalmology	Attendance	20,240	32,376
		Contact	1,400	2,424
		Cost weighted discharge	1,479	2,375
		Procedure	2,140	2,937
		Written plan of care	452	9
	ORL	Attendance	7,216	2,681
		Contact	1,054	1,454
		Cost weighted discharge	1,324	1,683
		Procedure	19	
		Treatment	1,047	1,681
		Written plan of care	47	0
	Orthopaedics	Attendance	14,221	1,835
		Bed days	5,100	
		Cost weighted discharge	8,299	948
		Procedure	3	
		Service	86,208	0
	Orthotics	Service	143,467	106,510
	Renal transplant	ADHB defined	0	1
		Attendance	120	161
		Cost weighted discharge	200	594
	Urology	Attendance	4,333	1,209
		Cost weighted discharge	1,458	2,094
		Procedure	131	184
		Written plan of care	343	104
Adult – medical	A Plus Links	Assessments	1,326	0
		Attendance	8,289	19
		Bed day	28,000	302
		Client	2,052	0
		Clients	570	0
		Contact	94,165	0
		Hour	9,000	0
		Programme	0	0
		Visit	3,292	0
	Critical care	Service	131,386	0
	Dermatology	Attendance	4,466	692
		Cost weighted discharge	85	48
		Procedure	1	0
		Programme	0	1
		Treatment	2,577	947
	Diabetes	Attendance	6,660	179
		Client	3,390	0
		Contact	2,980	34
		Item dispensed	10	2
		Procedure	6,000	474
		Written plan of care	221	0

			Proposed volumes	
HSG	**Hospital specialist service**	**Unit of measure**	**Auckland population**	**For other populations**
Adult – medical	Emergency medicine	Attendance	12,695	3,217
		Cost weighted discharge	2,745	653
	Endocrinology	Attendance	2,907	2,145
		Cost weighted discharge	100	106
		Test	2,875	492
	Gastroenterology	Attendance	7,411	771
		Cost weighted discharge	568	130
		Procedure	117	25
		Test	65	18
	General medicine	Attendance	1,526	44
		Cost weighted discharge	9,165	311
	Immunology	Attendance	1,766	3,547
		Contact	50	80
		Cost weighted discharge	230	299
		Patients	2	5
	Infectious diseases	Attendance	1,716	1,035
		Cost weighted discharge	184	89
		Service	119,034	386,613
		Written plan of care	50	
	Needs Assessment Service Coordination	Assessment	4,800	0
		Hour	4,331	0
		Programme	700,600	
		Service	1	0
	Neurology	Attendance	2,715	5,896
		Cost weighted discharge	980	679
		Procedure	1	13
		Programme	180,720	0
		Test	217	1,496
		Written plan of care	465	997
	Oral health	Attendance	4,487	11,470
		Completed treatment	3,830	9,609
		Cost weighted discharge	319	825
		Fitting of a prosthetic eye	20	67
	Rehab Plus	Attendance	697	0
		Day attendance	115	0
		Service	8,120	0
		Visit	3,537	0
	Renal medicine	Attendance	34,856	8,911
		Cost weighted discharge	1,116	347
		New client	57	13
		Patient months	1,449	19
		Service	224,350	0
		Written plan of care	70	3
	Respiratory medicine	Assessment	0	38
		Attendance	7,985	4,005
		Client	1,369	2,184
		Cost weighted discharge	2,000	1,535
		Premium	50,093	99,557
		Procedures	52	158
		Programme	0	11
		Service	0	0
		Test	355	195
	Rheumatology	Attendance	3,670	139
		Cost weighted discharge	63	7
	Sexual health	Contact	9,405	13,668
		Premium	521,161	884,160
		Service	182,231	416,681
	The Auckland Regional Pain Service	Attendance	850	273
		Client	18	21
Children's	Adult congenital heart	Attendance	136	275
		Cost weighted discharge	32	252
	Audiology	Test	6,250	3,374
	Child health and disability	Adjuster	140,032	0
		Client	304,234	0
		Contact	1,763	0
		Programme	342,776	0
		Service	353,819	0
		Test	546,130	0
	Developmental paediatrics	Attendance	886	105

			Proposed volumes	
HSG	**Hospital specialist service**	**Unit of measure**	**Auckland population**	**For other populations**
Children's (continued)	Developmental paediatrics GCC	Attendance	215	9
	General paediatrics	Attendance	11,786	478
		Cost weighted discharge	1,460	1,702
		Procedure	2	
		Programme	1,536	0
	Genetics	Attendance	485	1,174
		Clinical FTE	0	228
	Metabolic – paediatric	Attendance	52	120
	Newborn services	Attendance	737	673
		Cost weighted discharge	1,950	1,947
		Service	335,794	0
	Paediatric cardiac	Attendance	798	1,324
		Cost weighted discharge	621	3,651
		Written plan of care	0	668
	Paediatric dermatology	Attendance	442	391
	Paediatric emergency department	Attendance	11,650	7,137
		Cost weighted discharge	1,290	729
	Paediatric endocrinology	Attendance	1,026	2,670
		Client	103	345
		Cost weighted discharge	30	127
		Item Dispensed	9	8
	Paediatric family information service	Service	63,575	197,110
	Paediatric family options	Service	82,677	281,284
	Paediatric gastroenterology	Attendance	235	741
		Cost weighted discharge	138	533
	Paediatric haematology/ oncology	Attendance	1,787	7,807
		Cost weighted discharge	306	1,594
		Premium	134,984	1,018,062
		Programme	287,458	1,317,360
	Paediatric home health care	Service	24,099	14,516
	Paediatric immunology	Attendance	339	400
		Cost weighted discharge	20	90
		Patients	1	1
	Paediatric infectious diseases	Attendance	188	444
		Cost weighted discharge	27	119
	Paediatric intensive care unit	Service	0	0
	Paediatric neurology	Attendance	539	1,803
		Cost weighted discharge	63	624
	Paediatric neurosurgery	Attendance	117	535
		Cost weighted discharge	184	1,196
		Written plan of care	0	30
	Paediatric ORL	Attendance	4,169	1,799
		Cost weighted discharge	717	957
	Paediatric orthopaedics	Assessment	12	64
		Attendance	4,134	6,087
		Cost weighted discharge	1,003	2,825
	Paediatric pain service	Attendance	93	157
		Cost weighted discharge	0	1
	Paediatric palliative care	Attendance	721	1,087
	Paediatric renal medicine	Attendance	379	853
		Cost weighted discharge	30	249
		New client	0	3
		Patient months	18	121

			Proposed volumes	
HSG	**Hospital specialist service**	**Unit of measure**	**Auckland population**	**For other populations**
	Paediatric respiratory medicine	Attendance	342	1,050
		Client	14	146
		Cost weighted discharge	208	907
		Test	33	35
	Paediatric rheumatology	Attendance	144	545
		Cost weighted discharge	30	84
		Programme	0	1
	Paediatric surgery	Attendance	1,310	3,435
		Contact	0	0
		Cost weighted discharge	827	2,562
		Procedure	1	
	Whakaruruhau	Service	417,001	1,095,864
Cancer	Haematology	Attendance	10,932	8,654
		Cost weighted discharge	850	1,564
		Premium	114,653	588,209
		Programme	1,912,718	2,344,974
		Written plan of care	50	28
	Oncology	Attendance	27,986	86,005
		Cost weighted discharge	1,127	2,090
		Programme	3,416,928	9,407,032
	Palliative care	Programme	452,565	0
Cardiac	Cardiology	Assessment	0	47
		Attendance	7,433	1,273
		Client	1,340	5
		Cost weighted discharge	3,553	4,429
		Implant only	0	0
		Locally defined	297,006	0
		Programme	154,121	15
		Test	3,076	1,155
		Written plan of care	321	85
	Cardiothoracic	Attendance	182	518
		Cost weighted discharge	2,715	8,220
	Donor co-ordination	Programme	0	2
	Vascular surgery	Attendance	1,897	2,522
		Cost weighted discharge	1,352	2,381
Women's	Fertility Plus	Attendance	149	239
		Bed day	5	7
		Client	23	60
		Prescription	26,141	75,853
		Procedure	376	765
		Service	29	79
	Gynaecology	Attendance	8,986	3,098
		Cost weighted discharge	2,627	872
		Procedure	2,188	4,190
		Procedures	50	0
		Written plan of care	1,550	30
	Obstetrics	ADHB defined	0.31	0.00
		Attendance	11,021	7,718
		Client	330	178
		Contact	21,445	5,023
		Cost weighted discharge	6,120	2,741
	The Auckland Regional Pain Service	Attendance	460	331
Operations and clinical support	Adult allied health	Attendance	7,264	536
		Contact	1,130	1,354
	Clinical infectious diseases	Test	293	1,685
	Elective services	ADHB defined	227,307	0
		Service	330,712	0
	Imaging	Attendance	75	197
		Relative value unit	36,923	12,094
	Labs	Service	4,978,153	10,533,932
	Nutrition	Contact	5,990	7,284
	Women's and child allied health	Attendance	2,496	2,023
		Contact	1,150	2,011
Mental health and addictions	Specialist mental health service	Client	1	0

Production plan, summary total

Unit of Measure	Auckland DHB	Inter District Flow
Assessments	6,138.00	227.00
Attendances	284,823.00	240,751.00
Bed days	33,105.00	310.00
Clients	313,443.00	3,167.00
Contacts	141,121.00	33,335.00
Cost weighted discharges*	67,561.00	61,567.00
Fitting of a Prosthetic eye	20.00	67.00
Hours	13,331.00	-
Item Dispensed	19.00	10.00
Patients	1,527.00	163.00
Prescriptions	26,141.00	75,853.00
Procedures	11,501.00	8,796.00
Programmes	9,031,252.00	16,278,083.00
Services	8,505,497.00	13,058,355.00
Tests	559,295.00	8,450.00
Treatments	7,455.00	12,236.00
Visits	6,829.00	-
Written plan of care	3,569.00	1,975.00

* Contains Acute and Elective volumes

DHB Provider View

Summarised Outputs (DHB of Service)	Auckland			
	2010/11 Output Plan		% growth	% growth weights
	2010/11 Forecast	2011/12 Planned		
Case-weighted inpatient discharges				
Maternity	**12,297**	**12,757**	**3.74%**	**0.26%**
Medical	**49,143**	**50,781**	**3.33%**	**0.93%**
Medical electives	4,737	4,473	*-5.58%*	*-0.15%*
Medical acute	44,394	46,293	*4.28%*	*1.08%*
Medical other	11	15	*36.76%*	*0.00%*
Surgical	**63,198**	**65,604**	**3.81%**	**1.37%**
Surgical electives	*28,450*	*29,689*	*4.36%*	*0.70%*
Surgical acute	*34,748*	*35,915*	*3.36%*	*0.66%*
Surgical other	-	-	*0.00%*	*0.00%*
Total case-weighted inpatient discharges				
Total	124,638	129,143	3.61%	2.56%
Outpatient services (expressed as events)				
ED	30,699	34,699	13.03%	0.16%
Medical first	43,343	45,125	4.11%	0.12%
Medical follow up	125,054	130,691	4.51%	0.30%
Oncology	59,980	68,073	13.49%	0.46%
Renal	44,448	39,007	-12.24%	-0.43%
Scope	4,559	5,400	18.46%	0.12%
Surgical first	33,633	34,763	3.36%	0.05%
Surgical follow up	93,448	97,921	4.79%	0.14%
Other services (expressed as events)				
Maternity	37,703	38,436	1.94%	0.04%
Medical	51,252	54,927	7.17%	0.13%
Surgical	23,891	24,886	4.17%	0.03%
Health of Older People	29,140	30,440	4.46%	0.11%
Miscellaneous	225,348	238,955	6.04%	0.19%
All non-inpatient services (expressed as case-weighted outputs)				
Total	51,414	53,912	4.86%	1.42%
Total volume growth	**176,052**	**183,055**		**3.98%**

Explanatory Notes - Summarised Outputs (DHB of Service)

The information used to build the previous table was drawn from volume data in the 2011-12 Production Plan, and plan (2010-11) years. The table includes both internal and non-internal revenue. However, this table contains only a subset of the total Provider, which accounts for approx 70% of DHB Provider revenue.

All non-Case Weighted Discharge (CWD) volumes have been converted to a cost-weighted basis to allow counting of all outputs on a common basis with Case Weighted Discharges. The term used here to describe all volumes (inpatient and others) when weighted this way is Cost-Weighted Outputs (CWO).

Cost-weightings are carried out using purchase unit code National Prices as a proxy for the value of each output. This limits the scope of services counted to those purchase unit codes that meet two criteria: a national price must exist; and the unit of measure must be output (not input or programs) based.

The most important results in the table are those in the 'Total volume growth' line, which gives the percentage change in outputs across planned growth from 2010-11 to 2011-12.

In order to measure output growth across a set of years, the price (value) is fixed at the value for the latter year, and cost-weighted outputs counted across both years use these price values.

The volume numbers given in the lines for 'Outpatient services' and 'Other services' lines are events as reported in the Production Plan. The cost-weighted output equivalent for these services is given in a single line to wards the bottom of the table.

In all cases, the percentage growth figures shown are calculated as raw growth and as fractional percentages that sum to the bottom-line 'Total volume growth'. In other words, the fractional percentage figures indicate the contribution each line makes to total growth, and can be used to easily identify those lines that make the largest material contributions to overall growth.

The calculation Cost-Weighted Output
CWO = (Volume X the Purchase Unit Codes 2011-12 National Price) / 2011-12 Case Mix Price

Module 8: Financial Performance

Financial Management

The Minister's Letter of Expectations requires the organisation to achieve a break even position within the allocated funding. This requires reprioritisation and reallocation of resources and investment in tools such as lean thinking and the Health Excellence Framework in order to enable new ways of working, reduce variation and ensure avoidance of waste.

The significant pressure on cost growth, arising from increased service delivery requirements and the expectations of the labour market, means our drive to identify and implement new ways of working throughout the organisation is an imperative. This Annual Plan incorporates the requirement to avoid waste and improve productivity, including clinical resource utilisation and practice change and procurement savings. This includes maintaining management and administration FTE numbers below the Minister's December 2008 cap levels, with the processes and rules for managing below this cap now well established.

Key assumptions within the financial plans include:

- The world economic environment has increased uncertainty and risk in terms of there being a new world paradigm in which established historical practices and expectations may no longer apply, including uncertainty as to the future levels of donation income that will be received and the collection of payments from non-residents.
- Inflation is generally assumed at 2.75% with specific adjustments where future price changes are known. The potential future impact of the forex rate movements is also inherently uncertain in a small economy such as New Zealand operating in a global environment. A one percent inflationary movement in the non-employee operating costs equates to approximately $10 million at Auckland DHB
- Employee terms and conditions are subject to negotiation and interpretation. The impact of employee wage rate settlements have been estimated for inclusion in the financial plans, including agreed MECA settlements through to their expiry date and step increases within the MECA documents plus an allowance for future settlements pending negotiation. An estimate of the impact arising from job sizing has been included within the budget. A one percent variation in employee costs equates to approximately $8m at Auckland DHB
- There is uncertainty in property market values, particularly since the change in the world economic environment which has seen a downward movement in values. Given the uncertainty, it is assumed for budget purposes that there will be no change in the revaluation reserve and no change in the funding arrangements associated with the property revaluations. Board policy is to revalue land and buildings to fair value, as determined by an independent registered valuer, and this will be assessed at the end of each financial year and incorporated into the financial statements as appropriate.
- Productivity improvements are to be achieved by increasing the delivery of outputs at a greater rate than the increase in staffing inputs.
- As advised by the Ministry of Health, the future funding track for 2012-12 and 2013-14 is assumed to grow at the same dollar increments (being approximately 2.6% per annum) as occurred for 2011-12

As assumptions are made due to there being uncertain or unknown future events, they inherently represent a risk in that actual events may vary from the assumption. Similarly, actions which require a change from current processes and activities inherently represent a risk due to the need for a change in established practices and behaviours. Other specific issues and risks are identified in module 2.3 of this annual plan.

The financial plans include the estimated changes arising from the establishment of the new northern shared services organisation. Within the Statement of Financial Performance this mainly comprises reallocating the transferred expenditure and staff to be recorded as an outsourcing payment to the shared services organisation. Within the Statement of Financial Position this mainly comprises transferring certain assets to the shared services organisation with an offsetting financing transaction.

Capital expenditure projects for 2011–12

Provider Arm services prioritise their capital expenditure budget. The major projects being undertaken during 2011-12 or proposed for approval during 2011-12 are:

Greenlane Clinic Centre elective surgical facility	Stage one involving commissioning three new theatres and relocating and expanding the sterile supply dept has been completed. Planning is currently underway for further stages involving relocating clinics to create ward space
Car park at Auckland City Hospital	Construction work on the new Auckland City Hospital Car Park Building is underway with completion expected in December 2011. The total cost is $15million with $8.5million of this spend occurring in the 11-12 capital plan period
Building 10 exit and site development	Building 10 is a two storey, early 1900s structure which covers a key future development area on the Greenlane site. The Building 10 Exit Plan is releasing this area for the development of future clinical facilities. More than half the occupants have already been relocated (in particular IMTS). The 2011-12 capital plan includes a further $1.6million to move many of the remaining occupants out. Auckland DHB already holds a Resource Consent to demolish the building. This must be completed by March 2013
Starship Theatres Upgrade	A $27 million project to upgrade the existing theatres in Starship is proposed. These are the original 1991 design and their small size makes it difficult to accommodate the increased amount of equipment used in modern surgery. The project will also include two further operating rooms to enable surgery that is currently outsourced to be done at Starship. This project is subject to Crown approvals.

Financing for the above projects is to be provided from Auckland DHB cash flows and existing debt facilities.

Managing the funding

Overall funding allocations and service volume schedules, based on the funding envelope received in December 2010 have been developed. The 2010-11 figure is the contract volume (as per funding and accountability agreement with the Ministry of Health; and is used here for comparative purposes).

Acute case-weighted discharges

	For Auckland Population			*For IDF Population*		
Healthcare Service Group	**2010/11 (CWD)**	**2011/12 (CWD)**	**Comment**	**2010/11 (CWD)**	**2011/12 (CWD)**	**Comment**
Cancer	1,659	1,977	Oncology Volume inc.	3,499	3,654	Increase for services provided to with other DHBs
Cardiac	5,022	5,188	Volume inc to deliver on wait times & lists	8,401	8,734	
Children	8,183	8,713	Projected demand inc.	12,999	13,265	
Women	6,668	6,740	Population growth demand	2,662	2,723	
Adults	28,832	28,997	Includes Ophthalmology & ambulatory services	14,063	14,975	
Mental Health	na	na		na	Na	
Total CWD	**50,364**	**51,615**		**41,624**	**43,351**	

CWD = case weighted discharges

Elective case-weighted discharges

	For Auckland Population			*For IDF Population*		
Healthcare Service Group	**2010/11 (CWD)**	**2011/12 (CWD)**	**Comment**	**2010/11 (CWD)**	**2011/12 (CWD)**	**Comment**
Cancer	No CWD	No CWD		No CWD	No CWD	Increase for services provided to other DHBs
Cardiac	2,390	2,464	Mgt of waiting list	6,474	6,548	
Children	619	658	Demand forecast	2,991	2,688	
Women	1,357	1,417	Population growth demand	593	649	
Adults	10,720	11,406	High volume increase	8,043	8,332	
Mental Health	na	na		na	Na	
Total CWD	15,086	15,945		18,101	18,217	

The above elective work includes Health Target requirements

Non Case-weighted services

Non case weighted services have a variety of different counting methodologies and various reporting frameworks:

FSA (First Specialist Assessments) – the point of usual entry for patients who are referred from primary care or another specialist and or another DHB. This is considered key to the pipeline of delivering on elective discharges as well as giving confidence to referrers about access availability to Auckland DHB services. More and more, with practice changes, minor and low level treatments are also being performed (e.g. skin lesions removal)

FU (Follow Ups) – typically to monitor progress of a surgical intervention or medical course of medication. With the aging population and more chronic and long term disease management processes, particular patients are asked back periodically. Where feasible, this is being moved to primary care to allow continuity and local access

Programmes – encompasses a range of service activity, from screening programmes to nurse-led clinics

The percentage change from the current year's annualised activity is summarised and shown below:

Healthcare Service Group	Service Type	% Change ADHB	% Change IDF	Comments
Adults	FSA	6.7	7.0	Pipeline volume for 8% elective increases
	FU	3.3	7.1	Proportionate increase for post treatment checks & monitoring
	Programmes	9.5	-15.9	Increase for rehab; other DHBs will be providing local access & services
Cancer	FSA	-3.0	49.9	Local decrease but within timeframes & other DHBs to increase in order to meet national timeframes
	FU	-11.5	7.9	As above; locally, more liaison with primary care/GPs and use of virtual consultations
	Programmes	41.5	25.1	Overall planned increase to meet national 4 week time frame for radiation therapy
Cardiac	FSA	7.1	2.5	To continue local surgery throughput & demand growth
	FU	-7.3	1.1	Overall service shift to virtual consultations
	Programmes	6.9	14.9	Based on demand projections for rehab therapy
Children	FSA	-1.6	-5.3	Lowering need; but higher acute presentations (noted earlier)
	FU	8.5	-6.9	At ADHB, more ongoing monitoring for chronic illness; other DHBs intend to provide local access
	Programmes	0.1	-25.9	As above
Women	FSA	3.7	13.8	Increase to meet projected demand
	FU	-28.9	-34.2	Decrease due to 'first-time' treatments at FSA for low level interventions e.g. Mirena insertions, and use of primary care
	Programmes	10.2	9.0	Current utilisation projects growth upwards
Operations	Programmes	11.1	13.6	Increase in theatre & diagnostic services in line with projected acute growth and elective/FSA growth
	Total	**8.1**	**-2.5**	

It is likely that some of the proposed activity levels will be dependent on capacity and staffing. Thus, management decisions will be taken over the coming months on cost-effective ways of maintaining the necessary levels of activity.

NGOs and other services in community settings

Auckland DHB also funds a variety of community based services for the Auckland population, which are used by other DHB populations.

For Auckland population, there is a 2.9% increase, which is driven by government directed spending and growth in demand where there is a legislative entitlement to services. The larger 23% increase in Inter District Flows spend on NGOs is due to the estimated impact of patients from Counties Manukau DHB and other DHBs enrolled with the realigned Primary Health Organisations being managed by Auckland DHB.

NGO Services change from 2010/11 to 2011/12 ($m)

	Auckland		**Inter district flows**		**Total**	
	2010/11 ($m)	**2011/12 ($m)**	**2010/11 ($m)**	**2011/12 ($m)**	**2010/11 ($m)**	**2011/12 ($m)**
NGO Providers – 4% *Increase for extended LOS in maternity services. Other providers have no cost or demographic growth*	20.8	21.7	4.5	4.6	**25.3**	**26.3**
Community Pharmaceuticals – overall *6% increase based on Pharmac forecasts, new drug utilization and additional script fees*	93.3	97.5	26.5	29.9	**119.8**	**127.4**
Mental Health – no cost or demographic growth has been factored in yet.	18.0	18.0	15.0	15.0	**33.0**	**33.0**
Health of Older People -	96.9	99.1	8.1	8.2	**105.0**	**107.3**
Community Labs - 6*% for increase coverage/tests*	22.0	23.0	52	55.4	**74.0**	**78.4**
Community Palliative Care - *service change/development*	3.8	4.0	0.2	0.2	**4.0**	**4.2**
Primary Health Organizations – six *fold increase in IDF due to additional merged PHO register lists, & a directed 2% rise in 'first contact' rates*	110.2	112.4	3.4	22.6	**113.6**	**135**
Total ($m)	365.0	375.7	109.7	135.9	**474.7**	**511.6**

Module 9: Appendices

Appendix 1: Monitoring Framework Performance Indicators

The following table covers all the indicators of performance that the Government expects from district health boards. The first 6 are national health targets. Auckland DHB provides regular reports to the Ministry of Health on our progress against these targets. The suite of indicators below shows our activity in areas of usual business. These go beyond the targets already covered for 2011–12 in previous modules that focus on new areas of activity.

National performance measures	Ministry of Health indicator of performance	The Auckland DHB target for 2011–12
Health target Shorter stays in emergency departments	95% of patients admitted, discharged, or transferred from an emergency department within 6 hours	95%
Health target Improved access to elective surgery	The volume of elective surgery will be increased by an average 4,000 discharges per year (compared with the previous average increase of 1400 per year)	Meet elective discharge volumes, end of year target: 11,950
Health target Shorter waits for cancer treatment	Everyone needing radiation treatment will have this within 4 weeks of assessment	100% of people eligible for radiation therapy should receive treatment within 4 weeks of a decision to treat
Health target Increased immunisation	95% of two year olds are fully immunised by July 2012	95% of two year olds immunised (as part of regional target) 95% immunisation cover for 2 year old Maori tamariki 95% old immunisation rate for 2-year old Pacific children
Health target Better help for smokers to quit	95% of hospitalised smokers provided with advice and help to quit	95% of eligible hospitalised smokers by July 2012
Health target Better diabetes and cardiovascular services	Increased percent of eligible adults will have had their CVD risk assessed in the last five years	Maintain cardiovascular disease risk assessment by PHOs for eligible people, Maintain cardiovascular disease risk assessment by PHOs for eligible people, with an increase overall from 79% to 90% Cardiovascular risk screening (lipid and glucose or HbA1c) – Maori 90% – Pacific 90% – Other 90% – Total 90%
Health target Better diabetes and cardiovascular	Increased percent of people with diabetes attending free annual checks	Increase diabetes detection and follow up from the 2009-2010 targets as below

<table>
<tr><th>National performance measures</th><th>Ministry of Health indicator of performance</th><th>The Auckland DHB target for 2011–12</th></tr>
<tr><td>services</td><td>Increased percent of people with diabetes have satisfactory or better diabetes management</td><td>
<table>
<tr><td></td><td>Maori</td><td>Pacific</td><td>Other</td><td>Total</td></tr>
<tr><td>ADHB</td><td>60%</td><td>60%</td><td>60%</td><td>60%</td></tr>
<tr><td>Actual</td><td>888</td><td>3431</td><td>9787</td><td>14106</td></tr>
</table>
Increase the number of people receiving annual free diabetes check by 3% for total group i.e. 60%

Maintain good management of diabetes (HbA1c <8%) for Maori and Pacific at 2010 targets
<table>
<tr><td></td><td>Maori</td><td>Pacific</td><td>Other</td><td>Total</td></tr>
<tr><td>ADHB</td><td>72%</td><td>72%</td><td>80%</td><td>77%</td></tr>
<tr><td>Actual</td><td>639</td><td>2470</td><td>7830</td><td>10939</td></tr>
</table>
Increased referral to and participation in diabetes self-management courses by 5% total group

Increase retinal screening rate by 2% for people with diabetes for total group from 75% to 77%
</td></tr>
</table>

Policy Priorities Dimension

Performance Measure and description	2011-12 Target	National Target	Frequency
PP1 Clinical leadership self assessment The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: – Contributing to regional clinical leadership through networks – Investing in the development of clinical leaders – Involving the wider health sector (Including primary and community care) in clinical inputs – Demonstrating clinical influence in service planning – Investing in professional development – Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required Progress the measures identified to assess clinical leadership	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care The DHB is to supply a progress report on the implementation of changes to primary health care services that deliver on the core elements of Better, Sooner, More Convenient primary health care. In particular progress must be described regarding: 1. the shifting of services from secondary care to primary care settings; 2. the development of Integrated Family Health Centres; and 3. any specific reporting requirements that may be identified in the Minister's Letter of Expectations	No quantitative target qualitative deliverable required Progress on implementing primary care business case changes reported once a year as part of the quarter four report (as a report for metro-Auckland sub-region)	NA	Quarterly

Performance Measure and description	2011-12 Target	National Target	Frequency
And 1. Supply a progress report on the implementation of the business case(s) it is involved in. The BSMC Monitoring Framework includes indicators at three levels: 2. Supply a progress report on the operation and expenditure of the flexible funding pool, including how pool funding has been prioritised to deliver services to meet the four high-level objectives. Where problems are identified, resolution plans are to be described.			
PP3 Local Iwi/Māori engagement and participation in DHB decision making, development of strategies and plans for Māori health gain Measure 1 - PHO Māori Health Plans Percentage of PHOs with MHPs agreed to by the DHB Measure 2 - PHO Māori Health Plans Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) OR for newly established PHOs, a report on progress in the development of MHPs (list of the names of these PHOs) Measure 3 - DHB – Iwi/Māori relationships Provide a report demonstrating: – achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Māori health relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties during the reporting period – provide a copy of the MoU Measure 4 - DHB – Iwi/Māori relationships Report on how (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs) Measure 5 - DHB Māori Health Plan Provide a report by exception on national level priorities that have not been achieved in the DHB Māori Health Plan. The report will say why the priority has not been achieved, what the DHB will do to rectify it, and by when	100% of PHOs have Maori Health Plans agreed to by the DHB Provide appropriate District Health Board information so Maori can participate in decision making Consultation to inform the Auckland DHB Maori health plan 100% of Board members undertake Treaty of Waitangi training Participation in the Regional Inter-Sectoral Whanau Ora collaborative, contributing a health perspective Develop an integrated and comprehensive Whanau Ora outcomes framework Use the current workforce to address Whanau Ora and identify workforce opportunities to achieve Whanau Ora	100% 100%	6 monthly
PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Māori Measure 1: Provide a report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Māori. Measure 2: Report on examples of actions taken to address the issues identified in the reviews. The report should identify:• what issues/ opportunities were brought to your attention as a result of the reviews of pathways of care that	No quantitative target qualitative deliverable required Six-monthly reports describing the reviews of pathways of care undertaken that focus on improving health outcomes and reducing health inequalities for	NA	6 monthly

Performance Measure and description	2011-12 Target	National Target	Frequency
you identified in Measure one• the follow up actions you intend to take/ are taking as a result of the issues and opportunities that you identified above. The report should include timeframes for implementing the actions you identify.	Maori Show examples of actions taken to address issues identified		
PP5 Waiting times for chemotherapy treatment Provide a report confirming the DHB has reviewed the monthly wait time templates produced by either the relevant Cancer Centre(s) or its own DHB where treatment commenced at that DHB for the quarter Where the monthly wait time data identifies: – any patients domiciled in the DHB waiting more than four weeks, due to capacity issues, and/or – wait time standards were not met, for patients in priority categories A and B DHBs must provide a report outlining the resolution path.	100% achievement to target	100% at four weeks	Quarterly
PP6 Improving the health status of people with severe mental illness The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: – child and youth aged 0-19, specified for each of the three categories Māori, Other, and in total – adults aged 20-64, specified for each of the three categories Māori, Other, and in total – older people aged 65+, specified for each of the three categories Māori, Other, and in total	**Age 0-19** Maori 4.08% Other 2.30% Total 3.19% **Age 20-64** Maori 8.18% Other 2.93% Total 3.30% **Age 65+** Total 3.58% Actual extra no. of clients = 909	NA	6 monthly
PP7 Improving mental health services using crisis intervention planning Provide a report on: 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term	**Adult (20+)** Maori 95% Non Maori 95% **Child and Youth** Maori 95% Non Maori 95%	95% For all categories	6 monthly

Performance Measure and description	2011-12 Target	National Target	Frequency
clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.			
PP8 DHBs report alcohol and drug service waiting times and waiting lists Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. Reporting will be on the longest waiting time in days, plus the number of people on the waiting list for treatment at the end of the month, i.e. volume and time. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period	No quantitative target. Supply of quantitative data required Work with Waitemata DHB to get baseline information (NGO and provider arm services) for: • inpatient medical detoxification • social/residential detoxification • specialist prescribing • structured counselling • day programmes • residential programmes Results by ethnicity	NA	6 monthly
PP9 Delivery of Te Kokiri: the mental health and addiction action plan DHBs are to provide a summary report on progress made towards implementation of Te Kōkiri: the Mental Health and Addiction Action Plan. A template for this report can be found on the nationwide service framework library web site NSFL homepage: http://nsfl.health.govt.nz.	No quantitative target qualitative deliverable required	NA	Annual
PP10 Oral Health DMFT Score at year 8 Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are: – Decayed (D), – Missing (due to caries, M), and – Filled (F); and (ii) children who are caries-free (decay-free)	Maori 0.96 Pacific 1.10 Other 0.50 Total 0.80 **Total** Fluoridated Non-fluoridated	NA	Annual
PP11 Children caries free at 5 years of aged At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are: – Decayed (d) – Missing (due to caries, m), and – Filled (f)	Maori 60% Pacific 39% Other 80% Total 69% **Total:** Fluoridated Non-fluoridated	NA	Annual

Performance Measure and description	2011-12 Target	National Target	Frequency
PP12 Utilisation of DHB funded dental services by adolescents Total number of adolescents accessing DHB-funded adolescent oral health services for 2011-12, defined as: (i) the unique count of adolescent patients' completions & non-completions under the Combined Dental Agreement; and (ii) the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers) At the end of the quarter, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator	Total 77% of adolescents use dental services by 2012 (from 69% data 2010) Reduced inequalities for Maori and for Pacific compared to 'Others'	85%	Annual
PP13 Improving the number of children enrolled in DHB funded dental services Measure 1 - total number of children aged 0 to 4 years of age inclusive enrolled with DHB-funded oral health services Measure 2 - i) no. of pre-school and primary school children in total, and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (ii) the greatest length of time children have been waiting for their scheduled examination, and the no. of children waiting for that period	73% of 0-4 year olds enrolled 10% Children not examined 0-12 years	N/A	Annual
PP14 Family violence prevention Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components. (Data source: Provided to DHBs by the Auckland University of Technology (AUT) Hospital Responsiveness to Family Violence, Child and Partner Abuse Audit.)	Overall audit scores of 70/100 for child and partner abuse components of the Violence Intervention Programme Annual as part of quarter four report	140/200	Annual
PP15 Improving the safety of elderly: Reducing hospitalisation for falls The number of people 75 yrs and older hospitalised for falls domiciled in the DHB region, per year	Consistent methodology and target agreed across the region for falls prevention, by 1 August 2011 Programme to reduce falls implemented across Older People's Health and Aged Residential Care, by 1 February 2012	NA	6 monthly
PP16 Workforce - Career Planning The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with	No quantitative target. Supply of quantitative data required All trainees have a	NA	Annual

Performance Measure and description	2011-12 Target	National Target	Frequency
career plan for required categories: – Medical staff – Nursing – Allied technical – Maori Health – Pacific – Pharmacy – Clinical rehabilitation – Other	career plan in place With reports on trainees by ethnicity		

System Integration Dimension

<table>
<tr><th>Performance Measure and description</th><th>2011-12 Target</th><th>National Target</th><th>Frequency</th></tr>
<tr><td>SI1 Ambulatory sensitive (avoidable) hospital admissions

Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.
<table>
<tr><th>Ethnicity</th><th>Age group</th><th>Present rate</th><th>Reduction</th><th>Target</th></tr>
<tr><td>Maori</td><td>0-74</td><td>100%</td><td>1% - 2.9%</td><td>98.0%</td></tr>
<tr><td>Others</td><td>0-74</td><td>85%</td><td></td><td>Remain below 85%</td></tr>
<tr><td>Pacific</td><td>0-74</td><td>98%</td><td>1% - 2.9%</td><td>96%</td></tr>
<tr><td>Maori</td><td>0-04</td><td>64%</td><td></td><td>95.0%</td></tr>
<tr><td>Others</td><td>0-04</td><td>57%</td><td></td><td>95.0%</td></tr>
<tr><td>Pacific</td><td>0-04</td><td>97%</td><td>1% - 2.9%</td><td>95.0%</td></tr>
<tr><td>Maori</td><td>45-64</td><td>114%</td><td>3% - 5.9%</td><td>109%</td></tr>
<tr><td>Others</td><td>45-64</td><td>102%</td><td>1% - 2.9%</td><td>100%</td></tr>
<tr><td>Pacific</td><td>45-64</td><td>101%</td><td>1% - 2.9%</td><td>99.0%</td></tr>
</table>
</td><td>Please refer to the table below</td><td>NA</td><td>6 monthly</td></tr>
<tr><td>SI2 Regional service planning

A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan.

For each action the progress report will identify:
– the nominated lead DHB/person/position responsible for ensuring the action is delivered
– whether actions and milestones are on track to be met or have been met
– performance against agreed performance measures and targets
– financial performance against budget associated with the action

If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be</td><td>No quantitative target qualitative deliverable required</td><td>NA</td><td>Quarterly</td></tr>
</table>

Performance Measure and description	2011-12 Target	National Target	Frequency
provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan			
SI3 Service coverage Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through:• analysis of explanatory indicators• media reporting • risk reporting• formal audit outcomes• complaints mechanisms• sector intelligence	No quantitative target qualitative deliverable required Meet all service coverage expectations Report on any areas where there are exceptions to service coverage not approved as long term exceptions, and any other gaps in service coverage	NA	6 monthly
SI4 Elective services standardised intervention rates For any procedure where the standardised intervention rate in the 2011-12 financial year or 2011 calendar year is significantly below the target level a report demonstrating: 1. the analysis done to review the appropriateness of the DHB rate, and 2. whether the rate is considered by the DHB to be appropriate for our population or 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2011/12) that will ensure the target rate is achieved	Meet the Standardised Intervention Rates for the ADHB pop. at least 280 per 10,000 of pop. for casemix included elective discharges in a surgical DRG 18 per 10,000 of pop. for major joint replacement 9 per 10,000 of pop. for hip replacement 9 per 10,000 of pop. for knee replacement 27.0 per 10,000 of pop. for cataract procedures at least 6.23 per 10,000 of pop. for cardiac procedures The current national intervention rate for percutaneous revascularization is 10.8 per 10,000		6 monthly
SI5 Expenditure on services provided by Māori Health providers Measure 1: DHB to report actual expenditure (GST exclusive) on	No quantitative target. Supply of quantitative data	NA	Annual

Performance Measure and description	2011-12 Target	National Target	Frequency
Māori providers by General Ledger (GL) code Measure 2: DHBs to report actual reported expenditure for Māori providers in comparison to estimated expenditure for Māori providers in their Annual Plan for the same reporting period, with explanation of variances	required Complete the data and technical analysis required to build a picture of Maori expenditure across the Auckland DHB health system Report on progress by analysis of contractual commitments, identifying both Maori specific contracts, and share of mainstream Actual expenditure within mainstream Provider services specifically for Māori inpatients and outpatients by sub-specialty Predicted spend for Māori health in the 2011-12 Annual Plan		
SI7 Improving breast-feeding rates DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers	**6 weeks** Maori 64% Pacific 60% Other 74% Total 74% **3 months** Maori 55% Pacific 50% Other 65% Total 61% **6 months** Maori 24% Pacific 20% Other 32% Total 29%	74% 57% 27%	Annual

Ownership Dimension

Performance Measure and description	2011-12 Target	National Target	Frequency
OS3 Elective and arranged inpatient length of stay The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB's 'actual' ALOS, and the nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nation-wide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents, and summing the result across all discharge groups	4.00 bed days	NA	Quarterly
OS4 Acute inpatient length of stay The standardised ALOS is the ratio of 'actual' to 'expected' ALOS, multiplied by the nationwide inpatient ALOS. The DHB 'actual' ALOS, and nationwide inpatient ALOS, are both defined as the total bed days for hospital patients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for hospital patients (excluding day patients) during the 12 months to the end of the quarter. The 'expected' ALOS is derived by taking the nationwide ALOS for each grouping of patient discharges defined by DRG cluster and co-morbidities, multiplying this by the proportion of total discharges this group represents for the DHB, and summing the result across all discharge groups	4.00 days Moving towards 3.92 for 2012-13 (due to high-end complex service provision, ADHB has slower progress in reaching the national ALOS target) Transferred cases tend to be higher complexity and contribute to longer length of stay	NA	Quarterly
OS5 Theatre Utilisation Actual theatre minutes used / resourced theatre minutes = 85% Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility: – actual theatre utilisation – resourced theatre minutes – actual minutes used as a % of resourced utilisation Supply information on the NHB template. Baseline performance should be identified as part of the establishment of the target	85% Cardiac: By increasing the number of by-pass cases from 17 to 20 per week By maintaining the cancellation rate at 12% which is a reduction from current levels of 31%	85%	Quarterly
OS6 Elective and arranged day surgery Standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The 'actual' day surgery rate, and the nationwide day surgery rate, are defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). 'Expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG	60% standardised	62% Standardised	Quarterly

Performance Measure and description	2011-12 Target	National Target	Frequency
represents for the DHB, and summing result across all DRGs			
OS7 Elective and arranged day of surgery admissions The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a %	68% of elective and arranged surgery on a day of surgery admission (DOSA) basis Achieve targets for acute volume for Auckland residents	90% Standardised	Quarterly
OS8 Acute readmissions to hospital Standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage 'Actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. 'Expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB	9.95%	NA	Quarterly
OS9 30 Day mortality Standardised mortality rate is the ratio of the 'actual' to 'expected' mortality rates, multiplied by the nationwide mortality rate, expressed as a percentage. The DHB's 'actual' mortality rate, and the nationwide mortality rate, are both defined as the number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including daycases. The 'expected' mortality rate is derived using regression methods from the DRG and patient population characteristics of the DHB	1.39 mortality rate (The number of in-hospital patient deaths within 30 days of admission, as a proportion of all patient discharges, including Daycases)	NA	Annual
OS10 Improving the quality of data provided to national collection systems **Measure 1**: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns) **Measure 2**: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter **Measure 3**: Standard versus specific diagnosis code	NHI Duplications: 6% or less Ethnicity Not Stated in the NHI: 2% or less Standard vs. Specific	<6% <2% >55%	Quarterly

Performance Measure and description	2011-12 Target	National Target	Frequency
descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	Descriptor: 55% or more		
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter	National Minimum Data Set timeliness: 5% or less	<5%	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	>97%	>97%	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarter Denominator: Total number of PRIMHD records submitted by the DHB in the quarter	>98%	>98%	

Output Dimension

Performance Measure and description	2011-12 Target	Nat. Target	Frequency
OP1 Output Delivery Work delivered to contract	Acutes 100% Electives 100%	NA	Quarterly

PHO Performance Programme (Reported Quarterly)

We intend to report the indicators below by PHO and roll them up into business case groupings

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

Appendix 2: Consolidated Financial Tables

Table 1: Statement of financial performance

STATEMENT OF FINANCIAL PERFORMANCE	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
REVENUE					
Base Funding					
Population Based	930,233	961,555	987,170	1,013,425	1,039,680
Inter District Inflows	563,717	611,404	663,182	683,251	703,926
	1,493,950	1,572,959	1,650,353	1,696,676	1,743,606
Side Contracts with Ministry of Health					
Additional Electives	19,072	22,058	23,428	23,428	23,428
Sector Capability & Innovation	11,695	17,116	21,719	21,719	21,719
Other Side Contracts	58,581	52,285	54,147	54,147	54,147
	89,348	91,459	99,295	99,295	99,295
Other Revenue					
Other Patient Care	32,160	32,356	44,307	45,566	46,846
External Sales	59,240	59,937	55,594	56,999	58,328
Training	21,495	20,254	20,242	20,242	20,242
Donations	7,335	5,684	4,163	4,163	4,163
Financial	8,498	8,160	6,950	7,342	7,342
	128,728	126,392	131,255	134,311	136,920
TOTAL REVENUE	**1,712,027**	**1,790,810**	**1,880,903**	**1,930,282**	**1,979,821**
OPERATING COSTS					
Employee Costs	727,993	734,415	741,320	760,591	779,994
Outsourced Services	-	-	31,634	32,465	33,298
Treatment Costs	263,031	271,673	280,856	288,230	295,627
Funder Payments	448,216	504,995	557,683	572,324	587,012
Inter District Outflows	98,801	99,529	101,960	105,046	108,224
Property & Equipment Maintenance	49,338	50,839	45,750	46,944	48,149
Administration	20,040	24,225	22,619	23,212	23,808
TOTAL OPERATING COSTS	1,607,420	1,685,677	1,781,822	1,828,812	1,876,113
OPERATING SURPLUS/(DEFICIT)	104,607	105,133	99,081	101,470	103,708
NON OPERATING COSTS					
Depreciation	48,338	52,255	45,173	47,719	50,625
Interest	20,068	18,410	18,936	18,916	18,528
Capital Charge	35,921	34,408	34,873	34,734	34,452
TOTAL NON OPERATING COSTS	104,327	105,073	98,983	101,369	103,605
SURPLUS/(DEFICIT) FOR THE YEAR	**280**	**60**	**98**	**101**	**103**

Table 2: Statement of comprehensive income

STATEMENT OF COMPREHENSIVE INCOME	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
SURPLUS/(DEFICIT) FOR THE YEAR	280	60	98	101	103
OTHER COMPREHENSIVE INCOME					
Gains/Losses on Property Revaluations	(27,740)	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(27,460)**	**60**	**98**	**101**	**103**

Table 3: Cost of service statement

COST OF SERVICE STATEMENT	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
Governance & Funding Administration					
Revenue	8,825	4,892	6,385	6,557	6,728
Expenses	(13,779)	(5,785)	(6,308)	(6,480)	(6,654)
Net Surplus/(Deficit) - Governance & Funding Administration	**(4,954)**	**(893)**	**77**	**77**	**74**
Provider					
Revenue	1,142,081	1,158,982	1,212,062	1,245,559	1,276,295
Expenses	(1,149,126)	(1,178,757)	(1,212,047)	(1,245,539)	(1,276,273)
Net Surplus/(Deficit) - Provider	**(7,045)**	**(19,775)**	**15**	**19**	**22**
Funder					
Revenue	1,546,084	1,635,442	1,722,200	1,766,523	1,813,446
Expenses	(1,533,807)	(1,614,713)	(1,722,194)	(1,766,517)	(1,813,439)
Net Surplus/(Deficit) - Funder	**12,277**	**20,729**	**6**	**5**	**7**
Elimination					
Revenue	(984,963)	(1,008,506)	(1,059,745)	(1,088,358)	(1,116,655)
Expenses	984,963	1,008,506	1,059,745	1,088,358	1,116,655
Net Surplus/(Deficit) - Elimination	-	-	-	-	-
Total					
Revenue	1,712,027	1,790,810	1,880,903	1,930,280	1,979,814
Expenses	(1,711,749)	(1,790,749)	(1,880,804)	(1,930,179)	(1,979,711)
SURPLUS/(DEFICIT) FOR THE YEAR	**278**	**61**	**98**	**102**	**103**

Table 4: Statement of changes in equity

STATEMENT OF CHANGES IN EQUITY	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
Balance as at 1 July	478,719	454,579	458,807	462,499	462,600
Total Comprehensive Income	(27,460)	60	98	101	103
Capital Contributions from the Crown	3,320	4,168	3,594	-	-
Balance as at 30 June	**454,579**	**458,807**	**462,499**	**462,600**	**462,703**

Table 5: Statement of financial position

STATEMENT OF FINANCIAL POSITION	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
ASSETS					
CURRENT ASSETS					
Cash, Bank Balances & Investment Bonds	52,263	32,970	21,045	6,854	3,111
Financing Cash Deposit	10,500	21,000	31,500	42,000	52,500
Restricted Trust & Patient Funds	5,800	3,948	3,948	3,948	3,948
Receivables and Prepayments	59,785	60,840	62,967	64,005	65,237
Inventories	11,220	12,106	12,454	12,808	13,167
	139,567	130,865	131,914	129,615	137,964
NON CURRENT ASSETS					
Restricted Trust & Patient Funds	10,078	10,078	10,078	10,078	10,078
Property, Plant and Equipment	860,469	874,916	901,909	912,794	913,844
Intangible Assets	10,145	(1)	(1)	(1)	(1)
Derivatives in Gain	7,371	4,791	3,041	1,495	433
Investment in Associates	470	14,810	20,274	17,225	18,692
	888,533	904,594	935,300	941,590	943,045
TOTAL ASSETS	1,028,100	1,035,458	1,067,214	1,071,206	1,081,010
LIABILITIES					
CURRENT LIABILITIES					
Trade and Other Payables	136,394	137,626	147,027	148,917	154,244
Employee Benefits & Provisions	125,271	128,237	125,367	127,336	130,912
Borrowings	75,028	3,629	3,742	3,649	3,670
Funds held in Trust	1,068	1,103	1,139	1,175	1,211
	337,761	270,594	277,275	281,077	290,036
NON - CURRENT LIABILITIES					
Employee Benefits	22,435	22,952	23,246	23,246	23,898
Borrowings	213,013	283,105	304,194	304,283	304,372
Derivatives in Loss	311	(0)	-	-	-
	235,759	306,057	327,439	327,528	328,270
TOTAL LIABILITIES	573,520	576,651	604,715	608,605	618,306
EQUITY					
Public Equity	569,409	573,577	577,171	577,171	577,171
Accumulated Deficit	(477,375)	(477,315)	(477,217)	(477,116)	(477,013)
Revaluation Reserve	353,538	353,538	353,538	353,538	353,538
Trust/Special Funds	9,007	9,007	9,007	9,007	9,007
TOTAL EQUITY	454,579	458,807	462,499	462,600	462,703
NET ASSETS	1,028,099	1,035,458	1,067,213	1,071,204	1,081,008

NB. The organisation has joined a shared service agency as from 1 March 2011 and the movement in the Investment in Associates reflects the estimated investment in that entity.

Table 6: Statement of cash flows

STATEMENT OF CASH FLOWS	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
CASH FLOWS FROM OPERATING ACTIVITIES					
Cash was provided from					
Provision of Health Services	1,706,293	1,786,334	1,872,717	1,922,889	1,974,251
Interest Received	5,109	7,944	7,329	7,342	7,342
	1,711,402	1,794,278	1,880,045	1,930,230	1,981,592
Cash was applied to					
Employee Costs	(719,358)	(730,933)	(743,895)	(758,623)	(775,765)
Other Operating Costs	(905,989)	(987,251)	(1,065,932)	(1,101,054)	(1,127,741)
Interest Paid	(20,686)	(20,028)	(18,735)	(18,920)	(18,418)
	(1,646,033)	(1,738,212)	(1,828,562)	(1,878,598)	(1,921,924)
Net Cash Flow from Operating Activities	**65,369**	**56,067**	**51,483**	**51,633**	**59,668**
INVESTING ACTIVITIES					
Cash was provided from					
Proceeds from Sale of Fixed Assets	9	289	91	239	239
Decrease/(Increase) in Restricted Trust & Financing Funds	3,902	1,887	36	36	36
Decrease/(Increase) in Investment in Associates			(5,464)	3,049	(1,467)
	3,911	2,176	(5,337)	3,324	(1,192)
Cash was applied to					
Purchase of Fixed Assets and Intangibles	(45,126)	(71,201)	(72,166)	(58,648)	(51,719)
Net cash (Outflow) from Investing Activities	**(41,215)**	**(69,025)**	**(77,502)**	**(55,324)**	**(52,911)**
FINANCING ACTIVITIES					
Proceeds from Capital Raised/(Repaid)	3,320	4,168	3,594	-	-
Proceeds from Loans Raised	-	-	21,000	-	-
Net cash (Outflow) from Financing Activities	**3,320**	**4,168**	**24,594**	**-**	**-**
OPENING BANK BALANCE	**35,288**	**62,762**	**53,971**	**52,546**	**48,855**
NET CASH INFLOW/(OUTFLOW)	**27,474**	**(8,791)**	**(1,425)**	**(3,691)**	**6,757**
CLOSING BANK BALANCE	**62,762**	**53,971**	**52,546**	**48,855**	**55,612**

Table 6 (cont): Statement of cash flows

RECONCILIATION OF OPERATING DEFICIT WITH CASH FLOWS FROM OPERATING ACTIVITIES	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
Total Surplus/(Deficit) for the Year	280	60	98	101	103
Non - Cash Items					
Depreciation and Impairment Losses	48,338	52,255	45,173	47,719	50,625
(Gains)/Losses on Financial Instruments	(107)	2,270	1,750	1,546	1,062
Amortisation of Borrowing Costs	92	88	89	89	89
	48,323	54,612	47,012	49,354	51,776
Items Classified as Investing Activities					
Gain on Sale of Property Plant and Equipment	(77)	16	(91)	(195)	(195)
Movements in Working Capital					
(Increase)/Decrease in Receivables	2,838	(1,055)	(2,127)	(1,038)	(1,232)
(Increase)/Decrease in Inventories	497	(886)	(347)	(354)	(360)
Increase/(Decrease) in Payables	13,508	3,319	6,938	3,766	9,576
	16,843	1,378	4,464	2,373	7,984
Net Cash Flow from Operating Activities	65,369	56,067	51,483	51,633	59,668

Table 7: Balance sheet equity ratio

BALANCE SHEET EQUITY RATIO	2009-10 Actual $'000	2010-11 Forecast $'000	2011-12 Plan $'000	2012-13 Esimate $'000	2013-14 Esimate $'000
Equity Position					
Crown Equity	(444,504)	(448,697)	(452,353)	(452,418)	(452,485)
Trust Equity	(10,075)	(10,110)	(10,146)	(10,182)	(10,218)
Total Equity	(454,579)	(458,807)	(462,499)	(462,600)	(462,703)
	-	-	-	-	-
Total Debt					
Bank					
Bonds	(120,000)	(50,000)	(50,000)	(50,000)	(50,000)
Crown Funding Authority	(163,500)	(233,500)	(254,500)	(254,500)	(254,500)
	(283,500)	(283,500)	(304,500)	(304,500)	(304,500)
Total Debt	(283,500)	(283,500)	(304,500)	(304,500)	(304,500)
Total Debt + Equity	(738,079)	(742,307)	(766,999)	(767,100)	(767,203)
Equity Ratio - to be less than 65%	**38.4%**	**38.2%**	**39.7%**	**39.7%**	**39.7%**

Table 8: Summary of results by output class (module 4)

Summary of Results by Output Class

Output Class Service		Actual 2010 $'000	Forecast 2011 $'000	Plan 2012 $'000	Estimate 2013 $'000	Estimate 2014 $'000
Early Detection & Management	Revenue	418,117	433,911	526,423	539,083	553,023
	Expenditure	(420,608)	(435,854)	(528,134)	(541,084)	(555,160)
	Surplus/(Deficit)	**(2,491)**	**(1,943)**	**(1,711)**	**(2,001)**	**(2,137)**
Intensive Assessment & Treatment	Revenue	1,132,783	1,192,859	1,193,064	1,221,756	1,253,350
	Expenditure	(1,119,120)	(1,178,583)	(1,179,471)	(1,207,519)	(1,238,639)
	Surplus/(Deficit)	**13,663**	**14,276**	**13,593**	**14,238**	**14,712**
Rehab & Support	Revenue	138,383	145,027	144,382	147,854	151,677
	Expenditure	(148,830)	(155,459)	(155,441)	(159,247)	(163,388)
	Surplus/(Deficit)	**(10,447)**	**(10,433)**	**(11,059)**	**(11,393)**	**(11,711)**
Prevention Services	Revenue	22,741	19,011	19,353	19,819	20,331
	Expenditure	(23,187)	(20,852)	(20,078)	(20,561)	(21,092)
	Surplus/(Deficit)	**(446)**	**(1,841)**	**(725)**	**(742)**	**(761)**
Total	Revenue	1,712,024	1,790,808	1,883,222	1,928,512	1,978,382
	Expenditure	(1,711,745)	(1,790,749)	(1,883,125)	(1,928,410)	(1,978,279)
	Surplus/(Deficit)	**279**	**60**	**98**	**102**	**103**

Key lenders

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

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

Statement of Accounting Policies

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

Reporting entity

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

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

Auckland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions, e.g., laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

Statement of compliance

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

Basis of preparation

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

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

Basis for consolidation

Subsidiaries	Subsidiaries are entities controlled by Auckland DHB. Control exists when Auckland DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. Auckland DHB is the main beneficiary of the Auckland District Health Board Charitable Trust.
Associates	Associates are those entities in which Auckland DHB has the power to exert significant influence, but not control, over the financial and operating policies. Auckland DHB holds shareholdings in the following associates: Auckland Regional RMO Services Limited (previously The Northern Clinical Training Network Limited) (33% owned), Northern DHB Support Agency Limited (33% owned) and healthAlliance NZ Limited (20%). Auckland Regional RMO Services Limited is a joint venture company with Counties-Manukau and Waitemata DHBs, which exists to support and facilitate employment and training for Resident Medical Officers across the three Auckland regional DHBs.

Northern DHB Support Agency Limited with Counties-Manukau and Waitemata DHB exists to provide a shared services agency to the three Auckland regional DHB boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

healthAlliance NZ Limited is a joint venture company with Health Benefits Limited and Counties-Manukau, Northland and Waitemata DHBs that exists to provide a shared services agency to the four northern DHBs in respect to information technology, procurement and financial processing.

Transactions eliminated on consolidation

All inter-entity transactions are eliminated on consolidation.

Foreign currency

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

Budget figures

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

Equity

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

Property, plant and equipment (PPE)

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

Owned assets	Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses. Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. The latest revaluation was done on 30 June 2010. Additions to PPE between valuations are recorded at cost.
Disposal of property, plant and equipment	Where an item of property, plant and equipment is disposed of, the gain or loss recognised in the Statement of Financial Performance is calculated as the difference between the net sales price and the carrying amount of the asset.
Leased assets	Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. Operating lease payments are recorded as an expense in the Statement of Financial Performance on a straight-line basis over the lease term.
Subsequent costs	Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to Auckland DHB. All other costs are recognised in the Statement of Financial Performance as an expense as incurred.
Depreciation	Depreciation is charged to the Statement of Financial Performance using the straight line method. Land is not depreciated. Depreciation is set at rates that write off the cost or fair

value of the assets, less their estimated residual values, over their useful lives, as follows:

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

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

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

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

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

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

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

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

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

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

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

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

Employee benefits
Defined Contribution Plan (DCP): Obligations for contributions to Defined Contribution Plans are recognised as an expense in the Statement of Financial Performance as incurred.

Retiring Gratuities and Long Service Leave: Auckland DHB's net obligation in respect of Retiring Gratuities and Long Service Leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods calculated on an actuarial basis.

Annual leave, sick leave, continuing medical education leave and expenses
Annual leave is a short-term obligation and is calculated on an actual basis at the amount Auckland DHB expects to pay when staff take leave or resign.

Sick leave is a short-term obligation which represents the estimated future cost of sick leave attributable to the entitlement not used at balance date calculated as the amount expected to be paid.

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

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

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

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

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

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

Trust and special fund donations received are treated as revenue on receipt, in the Statement of Financial Performance. These funds are administered by the Auckland District Health Board Charitable Trust.

Interest income is recognised using the effective interest method.

Expenses
Payments made under operating leases are recognised in the Statement of Financial Performance on a straight-line basis over the term of the lease.

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

Income tax
Auckland DHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

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

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

Cost allocation
Auckland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:
Cost allocation policy: Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for direct and indirect costs: Direct costs are those costs directly attributable to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

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

Other Provisions
Surplus land
The procedure for disposal of Surplus land is subject to due process with regard to the New Zealand Public Health and Disabilities Act 2000, including Ministerial approval, Public Works Act 1981, S.40, the mechanism for protection of Maori interests in Crown owned land and any other interests registered on the title or under any other applicable legislation (e.g. Reserves Act 1977). Any surplus land is held at cost as property intended for resale. There are no plans to sell assets in 2011–12 or the outer years.

Appendix 3: Primary Care Business Cases

Better, Sooner, More Convenient Business Case Support

As noted in Module 3, section 8, DHBs are committed to supporting business cases to achieve their stated objectives subject to appropriate agreements being reached between all parties. The following sections are taken directly from the three business case work programmes, or have been provided by the business cases. They are included in this appendix to provide context for the DHB commitment of support made within Module 3 of this Annual Plan.

Note: Neither Alliance Health+ nor the National Hauora Coalition have any practices in Waitemata DHB

1. Alliance Health+ (AH+)

Alliance Health+ Primary Health Organisation ("AH+") is a consolidated entity made up of three former Pacific-led Primary Health Organisations ("PHOs"); TaPasefika PHO, AuckPac PHO and Tongan Health Society PHO.

The Alliance Health+ mission is:

"We will improve health outcomes and promote the wellbeing of Pacific peoples, families and all communities. We will achieve this by:

- Working with health providers, community carers and our enrolled population;
- Improving the scope and quality of health services, we will strive to serve as leaders in Pacific health regionally and nationally."

Action areas	To deliver for communities and patients	As measured by
Structural Change – Consolidation of Pacific PHOs	Maintain the consolidated PHO functions of AH+ and continue to identify efficiencies through this process so potential opportunities can be identified to allocate resources to the front line Continue to Strengthen Clinical Governance and Clinically led processes	PHO Performance Programme (PPP) data collection consistent and improved
Establishment of Integrated Family Health Centres In line with DHB locality plans	Better, Sooner and More Convenient - Improved and timely access for communities, families and patients where a range of services will be made available in one setting	Patient satisfaction survey Capture outcomes through the Results Based Accountability Tool: – How much did we do? (Volumes against Target / Volume growth) – How well did we do it? (Evaluation of intervention) – Are we better off? (Target Population Improvement). Utilisation rates of services within Integrated Family Health Centre of enrolled patients. Performance of national health targets for: Increased Immunisation, Child Health; Better CVD Services, Better Diabetes Services; Better help for Smokers to Quit. PHO Performance Programme targets achieved
Enhanced Primary Health	Providing an extended range of primary care health services to enrolled and non	Volumes of cases per Navigator / Care Co-ordinator to be agreed

Action areas	To deliver for communities and patients	As measured by
Care Services (Whanau Ora)	enrolled patients through Integrated Family Health Centres and also creating linkages to key social agencies for more holistic care i.e. whanau ora. This includes use of scheduling and community health wrap-around services to support patients and their families navigate and access social and healthcare services	once this service is resourced and operational. Also capture outcomes through the Results Based Accountability Tool: – How much did we do? (Volumes against Target / Volume growth) – How well did we do it? (Evaluation of intervention) – Are we better off? (Target Population Improvement).
Establishment of 4 Nurse-led services / networks	Focusing on early prevention screening and education with support by Community Health Workers/Social Workers/Youth Workers for patients and their families Develop a Nurse workforce, retention and recruitment programme that will enable and sustain nurse led clinics	Volumes for assessments to be agreed as Nurse led clinics / networks have been formally established PHO Performance Programme (PPP) targets achieved. Capture outcomes through the Results Based Accountability Tool: – How much did we do? (Volumes against Target / Volume growth) – How well did we do it? (Evaluation of intervention) – Are we better off? (Target Population Improvement)
New Population Health Programmes	Community Awareness and Health Education/Promotion programmes that continue to promote attitude and behaviour change in Pacific communities	Capture outcomes through the Results Based Accountability Tool: – How much did we do? (Volumes against Target / Volume growth) – How well did we do it? (Evaluation of intervention) – Are we better off? (Target Population Improvement)
Acute Demand Management	Collaboration with DHBs, GAIHN (Greater Auckland Integrated Health Network) and National Maori Coalition to address acute demand	
Alliance Leadership Team **The Role of the Alliance Health+ Alliance Leadership Team is as follows:** – Ensure initiatives and services are aligned with Alliance Health + Organisational Strategy and Business Plans and appropriately resourced, from a financial and human resource perspective; – Assist with resolving strategic level issues when requested by Alliance Health; – Use individuals influence and authority to advocate for Alliance Health + initiatives – Support Alliance Health	Strengthen the quality of decision making which ensure areas of prioritisation will benefit patients, families and communities	Alliance Leadership Team deliverables are met

Action areas	To deliver for communities and patients	As measured by
+ to adopt an evidence-based approach in project and service planning processes – Monitor the progress of initiatives – Ensure that projects are appropriately evaluated – Coordination of the Alliance Support Team (AH+ AST) – Advocate for required resources and skills to support the Alliance Health+ Alliance Leadership Team, Alliance Health + Alliance Support Team, and the implementation of initiatives and services within Alliance Health + business case		

2. The Greater Auckland Integrated Health Network (GAIHN)

GAIHN is an alliance of seven independent partners.

- Auckland District Health Board
- Auckland PHO Limited
- Counties Manukau District Health Board
- East Health Trust PHO
- ProCare Networks Limited
- Waitemata District Health Board
- Waitemata PHO.

The GAIHN goal is: "Better primary care to reduce the number of acute episodes which result in unplanned hospital admissions"

A key emphasis in the GAIHN approach is placed on empowering the alliance partners to manage a greater proportion of people's health care needs in community settings. GAIHN is also committed to ensuring that it maintains a second focus on reducing inequalities through all of its activity with a particular emphasis on better health of child health

To attain the GAIHN goal, and to address the second area of focus, a programme of work has been developed for the next 2-3 years

The fully integrated programme of work comprises seven aligned work streams

Workstream	Deliverables
Better Management of Targeted Individuals **(Workstream 1)**	Identify individuals (enrolled and non-enrolled) at high risk of acute events Encourage and facilitate individuals to enrol with a primary care provider (medical home) if they currently do not have one Ensure the primary care provider is aware of their enrolled high-risk patients Support the primary care provider in providing an individual care programme for their enrolled high-risk patients Milestones:

	– Risk Stratification tool delivered 30 September 2011 – Register of at risk individuals developed 30 October 2011
Better Primary Response to Acute Events **(Workstream 2)**	Building the capability of the primary/community sector to manage acute episodes through planning and implementing improvements to a range of options including: i. Triage ii. Primary Options for Acute Care (POAC) iii. Same day and urgent access to medical home iv. After hours availability v. Better management of self referrals vi. Others as necessary Milestones: – Range of options for acute triage developed by 30 September 2011 – Increased community based options, including Primary Options increased volumes (to 20,000) by 30 June 2012
Enablers of Better Individual Care **(Workstream 3)**	a. e-Practice: Integrating the multiple initiatives relating to electronically enabled best practice including; i. Access to Diagnostics ii. Clinical Pathways iii. Optimising Prescribing iv. e-Referrals v. e-Shared Care Planning vi. Advance Care Planning Milestones: – Integrated overview complete 30 September 2011 – Business Case developed 20 November 2011 b. Ensuring effective linkages with local health networks and locality approach to infrastructure development (e.g. Integrated Family Health Centres, Whanau Ora Centres and/or Community Health Hubs) c. Specialist support: Ensuring that the specialist support services needed to support enhanced primary care are developed including: i. Clinical Pathways ii. Access to Diagnostics iii. Nursing Development Project iv. Community Specialist Clinics v. Advanced Care Planning vi. Optimising Prescribing Project (clinical pharmacist support) d. Where appropriate, develop new organisational guidelines for models of care for people with long term conditions, in support of work streams 1 & 2 above
Population Prevention Programmes **(Workstream 4)**	Programmes to enhance community awareness and better self/whanau care to prevent or response to acute events including: a. Smoking cessation in primary care b. Cellulitis, prevention/early intervention c. Stroke d. Falls prevention e. Others Milestones: – Smoking Cessation programme rolled out to 50% of GAIHN practices – 30 June 2012 – Relevant and accessible stroke programme available 30 June 2012 – Relevant and accessible cellulitis programme available 30 June 2012 – Relevant and accessible fall prevention programme available 30 June 2012

Alliance Support and Development **(Workstream 5)**	All normal Management Office functions including: alliancing contracting, communications and engagement, funding partner capability building
Systems Improvement **(Provider Arrangements)** **(Workstream 6)**	a. Information project developing a better understanding of the drivers of acute demand b. Redesigned incentives and contracting Milestones: – Performance baseline established for acute demand by 22 July 2011 – Performance forecast counterfactual established & agreed by 19 August 2011 – GAIHN population performance reporting established by 23 Sept 2011 – PHO datasets and regular distribution established by 21 October 2011 – Practice level reporting in place by 18 November 2011 – Return on Investment formula established and agreed by 9 December 2011 – Incentives contract agreed by 23 March 2012 – Roll-out of education and training plan once the detailed work programme for intervening has been determined
Child Health Project **(Workstream 7)**	a. Incorporation of child health equity issues into 2011-12 focus on better management of acute events b. Development and planning for 2012-13 roll out Milestones: – Plan for commencement for child health project, March 2012

3. National Hauora Coalition (NHC)

The National Hauora Coalition is a national coalition of 11 Maori-led Primary Health Organisations (PHOs) which supports a range of primary care services for over 200,000 Maori and non-Maori high needs Whānau throughout New Zealand. The Coalition represents urban, rural and tribal groups that serve growing communities.

"Whānau Ora" is the driving force and ideology behind everything we do. For us, this means:

- Māori led, Māori owned and Māori protected
- A Whānau-centred approach that anticipates how the health sector activities interact with Whānau activities
- An integrated approach for improved outcomes across sectors
- Offering Māori experience Whānau-centred services

Our most important task is improving social and health outcomes for Maori and any other communities who use our services."

The year two implementation plan focuses on three priority areas:

1. Whanau Ora Clinical Outcomes

The National Hauora Coalition Clinical Governance Group have identified specific clinical outcomes for Year 2 under the Mama, Pepi, Tamariki and Oranga ki Tua (Long term conditions) focus areas

Standardisation and refinement of the Whanau Ora system

Year One involved the development of tools and systems which are being tested in demonstration sites. In year two these will be evaluated, refined and then rolled out across the National Hauora Coalition membership in a staged approach

2. Reconfiguration of the National Hauora Coalition PHO infrastructure

The merge of National Hauora Coalition PHO members under a national PHO agreement, from 1 July 2011, requires the consolidation of resources, systems and staff.

The change management process will ensure front-line services are uninterrupted and provider members continue to receive back office support functions

3. High Performing Organisations and Provider Networks

Producing a high performing organisation and high performing provider members involves the development of a fit for purpose framework. This framework will be linked to Results Based Accountability outcomes and will encourage kaupapa Maori, clinical and business excellence standards which will be defined and adopted nationally by the National Hauora Coalition and its provider networks.

Note: the target figures in the below are for the entire Coalition i.e. not just the Auckland region

Priority 1: Whanau Ora Outcomes

Objective	Action	By
Mama, Pepi, Tamariki Programme	• Increase breastfeeding rates • Increase Rheumatic fever screening rates • Percentage increase in children with B4 checks completed • Increase proportion of babies<1 enrolled	June 2012
Increase Immunisations rates	• Increased percentage of 2 year olds fully immunised	June 2012
Safe Homes	• Reduce smoking rates in homes/cars • Reduce smoking in pregnancy • Increase family violence screening • Increase insulated – damp free homes	June 2012
Reduce Emergency Department Presentation rates	• Improve cellulitis rates • Improve whänau education and self management of respiratory conditions • Improve whänau adherence to antibiotic use • Improved asthma management • Improved pneumonia management • Early screening/better management of chronic cough	June 2012
Oranga ki Tua Programme Improved CVD Risk Assessment and Management	• Increase % of patients eligible for a Cardiovascular Risk Assessment who have had a Cardiovascular Risk Assessment completed • Percentage with Cardiovascular Risk Assessment completed that have an active case managed care plan	June 2012
Improved Diabetes Screening and Management	• % patients with a TC/Cholesterol ratio above 4.5 mmol/l who are on a lipid lowering agent • % increase in DARs • % patients with HbA1c <8 • % of people with diabetes who have a cardiovascular risk of <15% • Increase diabetes screening and management rates	June 2012
Smoking	• No. of patients with smoking status recorded • No. of coded smokers offered brief advice to stop smoking • No. of people coded as smokers who have been offered smoking cessation support or referred to a provider	June 2012
PHO Performance Programme (PPP) Targets	• Active monitoring of performance in real time • Improve quality and clinical performance • Disseminate success stories and share learnings across the provider network • Focus on areas of underperformance and put remedial actions in place	Ongoing Mthly meetings Ongoing
Non PHO Performance	• Whänau Ora Clinical Governance to review and agree on	August 2011

Objective	Action	By
Programme Indicator • ASH rates • Breastfeeding • B4 School Checks • Oral Health	these target areas for 2011-12 • Develop Results Based Accountability indicators and performance measures for each identified programme • Pilot in providers • Evaluate effectiveness of programmes /interventions • Staged rollout across membership	June 2012
Whanau Ora Assessments	• Complete 2,900	June 2012
Case Management	• Complete 1,450	June 2012
Whanau Ora Centres	• Open 2 in Otara with provider members to open • Negotiate with members, the opening of 3 additional Whänau Ora Centres	Sept 2011 June 2012

Priority 1: Refinement and Standardisation of the Whanau Ora System

Objective	Action	By
Testing of the Whanau Ora Assessment, Case Management Tool and Processes	• Test the 3 whanau ora tools within 8 demonstration sites	October 2011
	• Te Hononga PHO will test their existing Mohio database system and processes.	October 2011
	• East Tamaki Health Care will test their existing system which uses a combination of their existing IT platform and clinical family navigators	October 2011
	• All other demonstration sites (Turuki, Papakura, Ngati Porou Hauora, Toiora, Kokiri Trust, Te Tihi Hauora o Taranaki) are testing the Whanau Ora triage assessment and case management tool developed by TOIORA PHO Coalition	October 2011
Evaluation of the Tools and Processes	• Recruit an external contractor to undertake evaluation	July 2011
	• Undertake formative evaluation	July – Sept 2011
	• Final report due	October 2011
National Rollout of Tools, Processes and IT Platform	• Work with provider members to introduce standardized suite of tools as recommended in the evaluation	December 2011
	• Purchase Results Based Accountability software license	July 2011
	• Train End Users	August 2011
	• Install in National Hauora Coalition Office and provider members	August 2011
1.2 Mama, Pepi, Tamariki and Oranga ki Tua Programme Development	• Establish Service Level Alliances (SALTS)	July 2011
	• Develop programmes	
	• Test in 3 demonstration sites	October 2011
	• Evaluate	Feb 2012
	• National rollout	March 2012
1.3 IT/IM Systems	• Connectivity of IT systems, including provider networks and National Hauora Coalition	Dec 2011
	• Develop Whanau Ora Dashboard in collaboration with PHO Performance Programme Manager	August 2011
	• Provide regular newsletters to members	August 2011
	• Update and maintain website	Ongoing
1.4 Reconfigure Alliance Leadership Team Structure	• Complete review of the interim Alliance Leadership Team	Sept 2011
	• Define funding arrangements / support for Alliance Leadership Team operations	July 2011
1.5 Workforce Development	• No. of practices willing to take undergraduate,	

Objective	Action	By
Plan	postgraduate and new graduate primary care staff • Increase Mäori/Pacific Island workforce • Develop individual professional development plan for regulated and unregulated workforce • Develop workforce plan for whänau ora/navigator roles - unregulated workforce • No. of new permanent multi disciplinary team members recruited into primary care with vocational registration	June 2012
1.6 Integrated Contracts	• Provide Results Based Accountability training to DHBs • Establish a Service Level Alliance to reconfigure existing services and develop a funding / contracting mechanism that integrate contracts/funds	June 2012
1.7 Te Ao Auahatanga Innovations contract	• Continue implementation of relationship strategy • Continued population of the national Maori health and social services database	June 2012

Priority 2. Reconfiguration of the National Hauora Coalition (NHC) PHO Infrastructure

Objective	**Action**	**By**
2.1 Plan Transition of Functionality to National Hauora Coalition	• Clarify functions of National Hauora Coalition PHO office • Establish structure, staff, resources, policies, processes, systems, branding • Review back to back agreements and revenue streams with provider members • Scope funding/business model • Build out National Hauora Coalition centre and regional platforms (locality networks) • Manage provider contracts	December 2011
2.2 HR Management	• Develop change management plan • Staff redeployment plan for Te Hononga staff • Manage staff /FTE transition from DHBs to National Hauora Coalition via devolution process	July 2011 July 2011 October 2011
2.3 Clinical Governance Structure and Functions	• Review clinical governance structure and membership as transitional Clinical Governance Group ceases on 1 July 2011 • Schedule regular practice visits with provider clinicians and GPs to ensure connection with the Whanau Ora strategy • Provide Continuing Medical Education, Continuing Nursing Education sessions	1 July 2011 Ongoing Ongoing
2.4 Grow and Retain National Hauora Coalition Membership	• Develop a "value add proposition" for existing members by undertaking a survey of member needs and expectations of the National Hauora Coalition • Roadshow (kanohi ki te Kanohi) schedule developed and actioned to grow membership	August 2011 July 2012 Ongoing
2.5 After Hours	• Actively contribute to the after- hours solution for primary care within metro Auckland • Commence discussions and develop plans of action to create accessible and affordable after hours solutions across our regional provider members	July 2012
2.6 Iwi Relationship Strategy	• Develop iwi accords which clearly stipulate the relationship, rules of engagement and functions of each party (National Hauora Coalition and Iwi)	July 2012
2.7 Governance	• Develop board KPIs based on outcomes framework	July 2011

Objective	Action	By
	• National Hauora Coalition strategic plan signed off (3-5 years)	July 2011
	• AGM to be held where board member composition will be reviewed to enable a fit for purpose board is in place for year two deliverables	November 2011

Priority 3: High Performing Organisation and Provider Networks

Objective	Action	By
3.1 High Performing Coalition Centre	• Review Governance composition and structure of membership to support the growth of the Coalition	November 2011
	• Undertake a fit for purpose assessment of the National Hauora Coalition based on the Baldridge model	July 2011
	• Develop KPIs, measures and goals against strategic and operational activities. Develop an organisational scorecard/based on outcomes	August 2011
	• Undertake survey of customer needs and wants, and tailor service provision/support to each provider member	July 2011
	• Review existing Clinical Governance Group structure, functions and membership at a national level and develop mechanisms to ensure regional connectivity	July 2011
	• Develop iwi accords with existing members and arrange kanohi ki te kanohi hui with additional iwi leaders. Meet regularly with iwi leaders forum	July 2012
	• Implement the newly developed communication strategy that addresses key stakeholders at multiple levels using various communication platforms	August 2011
3.2 High Performing Providers and Provider Networks	• Clarify regional/local roles and functions of a Whanau Ora network lead	July 2011
	• Develop KPIs for each Whanau Ora network lead based on the Baldridge model then monitor and provide support where required	August 2011
	• Benchmark key processes and results against high performing provider members and implement plans to get others up to speed	August 2011
	• Ensure all members are accredited providers (e.g. Cornerstone) or are in the process of gaining accreditation	July 2012
	• Improve IT interoperability across the provider network	December 2011
	• Develop local mechanisms for networks to share and disseminate successful interventions / practices / stories across the networks	August 2011
3.3 Clinical Governance	• Lead and support accreditation of all GP clinics, providers	
	• Develop clinical leaders across the network	
	• Develop and implement a clinical placement programme within networks	July 2012
	• Provide Continuing Medical Education, Continuing Nursing Education sessions, Professional Development Programmes	Ongoing

Appendix 4: Auckland DHB Board and Management

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

Board members

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

Management

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

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

Senior leadership team for Auckland DHB

Garry Smith	Chief Executive
Dr Margaret Wilsher	Chief Medical Officer
Taima Campbell	Executive Director of Nursing
Janice Mueller	Director Allied Health, Scientific, & Technical
Naida Glavish	Chief Advisor Tikanga

Children's Healthcare Service Group

Dr Richard Aickin	Director
Susan Aitkenhead	Nurse Director
Elizabeth Wood	General Manager - Starship (Acting)

Mental Health and Addictions Healthcare Service Group

Dr Clive Bensemann	Director
Anna Schofield	Nurse Director
Fionnagh Dougan	General Manager

Adult Healthcare Service Group

Dr Barry Snow	Director
Margaret Dotchin	Nurse Director

Cardiovascular Healthcare Service Group

Dr Peter Ruygrok	Director
Fionnagh Dougan	General Manager

Women's Healthcare Service Group

Maggie O'Brien	Midwifery Director
Vacant	Director
Vacant	Nurse Director
Kirsty Walsh	General Manager (Acting)

Cancer and Blood Healthcare Service Group

Dr Richard Sullivan	Director
Fionnagh Dougan	General Manager

Senior team that support activity across the organisation

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