AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

2013/14 Annual Plan

Incorporating the Statement of Intent

Auckland District Health Board

26 July 2013

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

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

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

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

29 JUL 2013

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

Dear Dr Levy

Auckland District Health Board 2013/14 Annual Plan

This letter is to advise you I have approved and signed Auckland District Health Board's (DHB) 2013/14 Annual Plan for three years.

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

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders
The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets
Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

Auckland DHB is performing well in most target areas. However, in the year ahead I expect Auckland DHB to particularly focus attention on maintaining the recent pattern of improving performance for the primary care component of the Better help for smokers to quit target, and the More heart and diabetes checks target.

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

Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I expect that DHBs will use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

I expect DHBs to increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. I expect DHBs to work in partnership with primary care, using their Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB has developed your Annual Plan jointly with your PHOs. I look forward to seeing the results of your work to improve the breadth of services with direct access from primary care. In particular, through the implementation of direct access to elective lists for skin lesions, mirena insertions and ring pessaries, pipelle biopsies, cervical polyps, tubal ligations and pre-termination assessments. It is positive that you are implementing primary care direct access to specialist advice for paediatrics, renal, diabetes, cardiology, general medicine and general surgery while maintaining the access primary care already has to a full range of X-rays and ultrasounds and your 'primary options to acute care' programme. Continuing to reconfigure your NIR services will contribute to further integration for your DHBs.

Health of older people

The Government expects DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to review your wraparound services, roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. I expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means

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

I am pleased to see that your DHB is planning to break even for the next three years. I will be watching with keen interest your delivery of the improvement initiatives supporting your planned net result.

Budget 2013

The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval

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

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

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

The Auckland District Health Board Annual Plan for 2013–14 is signed for and on behalf of:

Auckland District Health Board

Dr Lester Levy
Chair

Date 26/6/13

Dr Lee Mathias
Deputy Chair

Date 26 June 2013

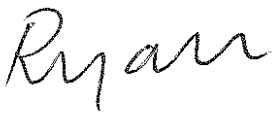
Our Te Tiriti of Waitangi partners
Te Runanga o Ngati Whatua

R Naida Glavish JP
Chair, Te Runanga o Ngati Whatua

Date 25 · 6 · 2013.

And signed on behalf of

The Crown



Hon Tony Ryall
Minister of Health

Date

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MODULE 1: Introduction

Foreword from the Chair

While the Auckland District Health Board is on the whole performing well, our Board thinks at this point in its journey the organisation can and must do better. After all the Auckland District Health Board plays a critical role, not just within our district, but also as a regional and national provider of services. Around half our services are provided to patients from other District Health Boards, with many of these services having a complexity and degree of specialist expertise not available at other District Health Boards. As there are no or limited alternatives for these patients as well as our own local population, our organisation needs to be performing to its highest potential. We should be aspiring to not just meet, but to exceed targets as we build bolder and more ambitious plans for what we can achieve for our patients and population.

At the heart of the matter is the need to unlock the full potential inherent within the organisation while developing a much deeper philosophy and capability around keeping our district population well. This is in addition to providing them with timely access to the clinical interventions they need. Harnessing the talents and skills of all our people will be key to this.

It all starts with a change in culture and mindset. At this point I would like to make a very important clarification and that is to shatter the prevailing myth that organisations need to change because they are broken and that to change means discarding the past. The reality is that we need to change because our context (and that of other health organisations) is changing (dramatically and at speed) and also that successful adaptive change builds on the past rather than discarding it. I would also like to reanimate the meaning of culture which is all too often interpreted as being what it feels like to work in an organisation rather than what it is – the specific focus of the organisation.

I observed the need for a change in the culture and mindset in the early months of my Chairmanship. In my view this change is required because the Auckland District Health Board has not kept pace with the speed of the changing context. I sense that the culture of the organisation needs to become more outward focused to one that emphasises the utmost levels of care and consideration for every single patient (and their family) and puts the health status of our population at the forefront of every decision we make. We need to develop a culture that promotes greater levels of autonomy for self directed patient care and one in which our patients and population have access to much more information to assist them in better managing their health.

We need a greater sense of urgency and commitment to finding innovative models of care and key to this is becoming very much better at working collaboratively with others. A critical part of the requirement for a re-calibration of the culture at the Auckland District Health Board is to

ensure absolute consistency of quality, greater transparency, enhanced accountability and much stronger fiscal responsibility.

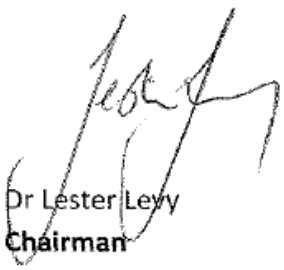
But culture and mindset change is not an overnight process and consequently we have no time to waste in building a momentum for change which will extend to every facet of our services.

Last year saw a significant renewal of our senior executive leadership team, with a new Chief Executive, a new Chief Financial Officer, a new Director of Nursing, a new Director of Allied Health and Technical and a new General Manager of the Mental Health service. Key new appointments were also made in the executive and clinical management of flagship services such as Starship and Children's Health and National Women's Health. All of these appointments will play an important part in moving the organisation onto a new trajectory.

As I said previously, while the organisation is performing well enough, there remain a number of key issues that have not been previously recognised or dealt with and resolving these is a critical priority and under the leadership of the new Chief Executive the Board expects a move to anticipate and better manage both risks and issues.

Sir William Osler, sometimes called the father of modern medicine said, 'The good physician treats the disease; the great physician treats the patient who has the disease.' In the same way that it might not be possible for there to be good and great in the same physician, I think that there cannot be good and great in the same organisation – at Auckland District Health Board good needs to be pushed aside to make way for great.

Our sublimely talented people, our wonderful concentration of intellectual capital, our brilliant assets, our partnerships and relationships as well as our financial resources leaves me feeling very optimistic that if we properly confront the reality of where we currently are – we will be able to get to where we need to be.



Dr Lester Levy
Chairman
Auckland District Health Board

Foreword from the Chief Executive

Auckland DHB's role is to support the population of Auckland to maximize their health and well being, to ensure people have access to safe and effective services, and to focus on reducing the impact of diseases which cause the most suffering. The greatest burden of health for the Auckland district health board is from cancer, followed by heart disease, chronic obstructive pulmonary disease, diabetes and transport accidents.

We also focus on reducing health inequalities in our population. A baby boy born today in the Maungakiekie-Tamaki ward can expect to die 6.5 years earlier than a baby boy born just up the road in Orakei ward. It is clear that spending more money on health care, even if we had it, will not in itself close this gap between groups.

We need to understand what's important to people, to families, whānau and communities, particularly what motivates and influences people in their decision-making around health. We need a new relationship with our population, one based on an expectation that they will be managing their own health and the district health board is here to help. Self directed care is based on this premise.

Through the development of localities we plan to work closely with the people we serve. There will be new partnerships, not only with the people of the localities but with others who contribute to the well being. This recognises that health services alone cannot impact on the major determinants of health.

The current way we go about our business is unsustainable. There is a growing need for services arising from our aging population, along with increases in the cost of services, driven in part by new technology. Focusing on prevention and on new models of care based on self directed care will help us to provide the kind of health care our population deserves.

Auckland DHB is a major provider of secondary, national and regional services. Half of the income of the provider arm of Auckland DHB comes from other DHBs. As a provider we must provide safe and effective services to the highest clinical standards and as required by the DHBs who buy services from us. Our provider arm must increase its efficiency and build on its well-deserved reputation for high quality services to develop new more cost effective models of service. We must develop transparent costing models for those services and decision making processes about service provision with other DHBs.

We are thus in a period of rapid and sustained change. This Annual Plan signals the start of that journey. The details and implementation of Self Directed care will be described more fully in subsequent strategic documents developed with partners and the people we serve.

Ailsa Claire
Chief Executive

Te Tiriti o Waitangi Statement

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

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

- Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with manawhenua at a governance level
- Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities
- Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation
- Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Guiding Principles

The following nine principles underpin the Auckland DHB work streams and approaches and provide practical direction for the identification of Māori health priority areas and associated activities and indicators.

Health partnership with manawhenua

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

Commitment to Māori communities

The commitment to Māori communities is given expression through manaaki tangata obligations which are central in the provision of manawhenua responsibilities being delivered in conjunction with the kawanatanga obligations of Auckland DHB. Commitment to Māori communities therefore demonstrated through their engagement and input into decisions affecting the health and independence of Māori communities.

Whānau ora

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

Health equity

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

Self-determination

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

Indigeneity

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

Ngā kaupapa tuku iho

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

Whole-of-system responsibility

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

Evidence-based approaches

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

The Context of this Annual Plan

Who we are and what we do

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

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

The Auckland district encompasses six central wards of the Auckland Council. Approximately 470,000 people live in Auckland DHB and this number is growing due to the increase in housing stock in Auckland and the inwards migration of people to the Auckland region. New strategies are being implemented to meet this growing demand. Of paramount importance is improving the efficiency and effectiveness of services. We need to work in new ways, with primary care and with our regional DHBs, to reduce the rate of increase in services such as emergency department attendances, inpatient bed days and general practice attendances.

Snapshot of Auckland DHB

- Over 470,000 people live in our DHB area, with a projected growth of 19% or 87,950 more people by 2026
- We are a diverse population: 8% Mäori, 11% Pacific, 31% Asian, 50% Others
- Auckland has one of the highest non-English, non- Māori speaking areas with over 100 different languages spoken
- 13% of our population need assistance or interpreting when attending health services
- Our population is relatively young: 17% are aged under 15 years, compared with 19.8% for all of NZ; and 10% of people living in the Auckland DHB district are aged 65 years and over, compared with 14.67% of the NZ population
- 34% of our population live in areas with a New Zealand deprivation index of less than 7 (10 is the highest level of deprivation)
- Over 38% of all 0–14 year olds live in the highest deprivation areas of the city (NZ Dep 8, 9 and 10). Of that 38%, 72% are Pacific, 55% are Mäori and 21% are 'Others'
- Cancer and heart disease remain the biggest health problem areas for our district

Please refer to our website: www.adhb.govt.nz for more information on our population profile and for other material that explains the DHB's role and activities.

Nature and Scope of Activities

The district health board has four key roles:

- **Planner -** DHB planning begins with an assessment of population health need. This establishes the specific focus within our district that need to be managed alongside national and regional priorities. Local needs inform the Northern Region Health Plan, our Māori Health Plan, and this Annual Plan
- **Funder -** Our funding responsibilities cover all services delivered for our population: hospital-based services provided at Auckland City Hospital and Greenlane Clinical Centre, and community based services such as primary care, aged residential care, home based support services, community pharmacy services, community mental health services, and district nursing
- **Provider -** Auckland DHB provides specialist hospital services as well as secondary hospital and community health services to people living in our district, and to people from other parts of New Zealand. Specialist services are delivered from Auckland City Hospital (New Zealand's largest public hospital and clinical research facility), Greenlane Clinical Centre, and the Buchanan Rehabilitation Centre.

  Services for the whole country include organ transplant, organ and tissue donation, specialist paediatric services and high risk obstetrics. Other tertiary services such as clinical genetics and paediatric oncology are provided for people in the Northern, Midland and Central regions.

  Auckland DHB also provides public health services, cardiac surgery and other interventions for the Northern region. Over half of the work done within our hospitals is for people from other districts.

  The Auckland Regional Public Health Service (ARPHS) is managed by Auckland DHB and provides regional public health services to Auckland, Counties Manukau, and Waitemata district health boards under a contract to the Ministry of Health. The service is responsible for improving population health outcomes and reducing inequalities. It also provides quick and effective responses to outbreaks, environmental hazards and other emergencies. This reduces downstream expenditure on the consequences of uncontrolled health threats. Other public health services, e.g. health promotion and healthy public policy, also help to reduce demands for personal health services though influencing medium and long-term health outcomes.
- **Owner of Crown Assets –** Auckland DHB operates in a financially responsible manner and is accountable for the assets we own and manage. We are responsible for ensuring strong governance and accountability, risk management, audit, and performance monitoring and reporting.

  The DHB functions through a governance structure based on the requirements of the New Zealand Public Health and Disability Act. The Board has eleven members: seven elected and four appointed by the Minister of Health. Board members provide strategic oversight for the DHB, taking into account the Government's vision and priorities for the health sector. Three statutory advisory committees assist the Board to meet its responsibilities. Meetings of the Board and committees are open to the public.

Other interests

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB. We are a shareholder in a number of Crown Entity subsidiaries: Northern Region Alliance (formerly the Northern DHB Support Agency Limited), Northern Regional Training Hub Limited, New Zealand Health Innovation Hub Management Limited, and healthAlliance NZ Limited. Canterbury, Counties Manukau, Waitemata and Auckland DHB are limited partners in the New Zealand Health Innovation Hub.

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

The Northern Regional Alliance Limited has applied for exemption from producing a Statement of Intent (SOI) for the 2013-14 year as a restructuring process is under way and key outputs and budgets are not able to be set until the new structure is in place. The Northern Regional Alliance Limited will produce a Business Plan including budgets and key outputs for 2013-14 and will report internally and to shareholding DHBs against that business plan commencing with a report in October 2013 for the first quarter of 2013-14.

The Northern Regional Alliance Limited Annual Report for 2013-14 will report actual results against the Business Plan in a similar manner to that which the two amalgamated companies reported against their annual Statements of Intent. The shareholding DHBs will monitor NRA performance against its Business Plan on a quarterly basis during 2013-14.

There are no plans to acquire shares or interests in any other company, trusts and/or partnerships.

Factors Affecting our Performance

DHBs across the Auckland region face similar challenges: population growth and ageing, increasingly diverse communities, and a growing demand for health services (and the infrastructure to support these).

DHBs also work within a tightening financial environment where health spending is forecast to grow much more slowly than previously. The challenge is to offer, and in some cases grow, quality health services within the funding available. We also need to prepare for the future make-up of the population, i.e. there are going to be fewer people of working age; the number of people of retirement age compared to those of working age is forecast to double.

Areas of risk and opportunity

Risks	**What's required**
Long-term fiscal sustainability	Clear prioritisation across all areas of the sector Tight cost control to limit the rate of cost growth pressure Purchasing and productivity improvement to deliver services more efficiently and effectively across both community and hospital providers Service reconfiguration to support improved national, regional and local service delivery models, including greater regional cooperation.
Diversity of need within NZ's population, including a growing number of older people with multiple conditions	Assist people and their families to manage their own health in their own home Specialist services delivered in community settings as well as hospitals Focus on proven preventative measures and earlier intervention.
Growing demand for health services	Accelerating the pace of change in key areas: • Moving intervention upstream • Meeting the diversity of needs within the population • Driving investment towards better models of care • Integrating services to better meet people's needs • Improving performance • Strengthening leadership while supporting front-line innovation • Working across government to address health and other priorities.

MODULE 2: Strategic Direction

2.1 Auckland DHB Future Direction

Vision statement

Healthy Communities, Quality Healthcare ~ Hei Oranga Tika mo te iti me te Rahi

We want a healthy population where people are empowered to manage their own health and wellbeing, and who get the very best of health services when they need them. When people are unwell they rely on us to deliver the right care, at the right time, and in the right way.

In 2013-14 we will focus on meeting the national health targets and all other government priorities. We will work closely with our neighbouring DHBs so that the four DHBs in our region deliver all the activities in our Regional Health Plan.

It is also a developmental year. We need to do more strategic planning, especially to understand how Self Directed Care can contribute to patient health and wellbeing.

Self Directed Care

Self Directed Care is the key approach to achieving our vision. The final form of Self Directed Care is not yet agreed and won't be rushed. Many stakeholders need to be engaged in this process. We need to work in a way that supports the people of Auckland to maximise their health and well being, and in so doing reform the way we go about our business.

This is not only the right thing to do but there is a strong economic argument to support this model. It will affect all aspects of relationships across the system including the contract between the public and the care givers. While this is a long term commitment, we need to get started with partners in the 2013-14 financial year. This programme will also involve Waitemata DHB.

There is work we can do now that will have a significant and quick impact. For example, the policy work underway to see families and whānau as partners in patient care will roll out in 2013-14. This will involve changes in practice across our inpatient services. Other work-streams are already working this way and will be supported to build on these strengths, e.g. mental health, Whānau Ora contracting, health of older people, and our localities work.

A large number of patients are required to attend routine appointments at hospital after being discharged. Over the year, we will review the need for routine Follow Up appointments and whether there are safer and more convenient ways to monitor patients after treatment.

Self Directed Care is one of the key ways to:

- Support people to maximise their health and wellbeing
- Achieve the outcomes people want for themselves, their families and their communities
- Achieve safe, high quality, evidence-based service delivery

- Provide the best return on investment in health

Self Directed Care has been operationalised in other places with great success. For example:

- Cultural change based on trust and partnership
- OD programme e.g. everyone trained in motivational interviewing
- Participation and engagement processes
- Open transparent two way communication between population and people who service them
- Care navigation
- Costed care pathways with financial and care control devolved as far as possible
- Integrated patient information systems across all care settings
- Integrated training
- Community educators
- Telecare and Telehealth
- e-clinical pathways
- e-benchmarking, (Atlas of variation)
- Predictive risk modelling
- Insight based service design
- Open data and transparency of data
- Peer education models

Considerable advances in infrastructure are needed to support this way of working. While there are some great examples of work already in place, we need to beef up the supports. Wrap around care, care navigators and shared access to patient records are all key to Self Directed Care. Each of these needs to be supported by information technologies, human resource development and, most importantly, a shift in power from the health professional to the patient and their family.

Insight-based service design, open transparent data on service quality, digital two-way communication and meaningful intelligence will be essential to ensure that everyone, whether a patient, clinician or other caregiver, makes the best decisions they can.

Bringing about a change of this scale will be difficult. Work will start in 2013-14 but Self Directed Care is a strategy that will take time. It relies on partnerships across the care system, and with patients and communities that are still developing. The potential for heath and economic gains compels us to start this journey.

Our Values

Kia u ki te tika me te pono

Integrity Respect Innovation Effectiveness

2.2 Strategic Context

National

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

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

For 2013-14 the government continues to expect better, sooner, more convenient healthcare services for patients and communities, delivered within constrained funding increases.

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

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

Accelerating the work with national health sector agencies – Health Benefits Limited, Health Workforce NZ and Health Quality and Safety Commission – is also expected. Strong clinical leadership and engagement remains essential to achieving clinical and financial gains for the sector.

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

A national service improvement programme is underway involving (for the 2013-14 year). Patient care, access, and clinical and financial viability can be improved through a national approach including:

- Intestinal Failure
- Renal Transplantation
- Hyperbaric Medical Service
- Complex Epilepsy

The appropriate planning, funding, contracting and monitoring supports will be put in place for these projects. Auckland DHB will continue to support national services and national service improvement programmes.

Regional

In partnership with the other northern region DHBs, we want the best health outcomes from the available resources. We will continue to focus on:

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

The Northern Region Health Plan (our regional services plan) was developed by the four Northern Region DHBs to provide an overall framework for future planning and to clarify regional priorities. Emphasis has been placed on Better, Sooner, More Convenient health care. This ensures good integration of activities across all care settings covered in the plan. Drawing on strong clinical leadership and a whole-of-system approach, we have identified the priority areas to address in 2013-14. Tangible benefits are defined by which to assess performance (http://www.ndsa.co.nz/FormsDocuments.aspx)

Faster implementation of regional service plans is expected, including objectives for workforce, information technology and allocation of capital.

Sub-regional

Auckland and Waitemata DHBs have a bi-lateral agreement which joins governance and some activities where there is mutual benefit. Regionalisation through collaboration is a strategic priority for both Boards who together provide health services to over one million Aucklanders.

The two DHBs share a Board Chair and have advisory-committees that meet jointly. The merger of the primary care Planning and Funding Teams has increased consistency of relationships and primary care management across the two DHBs. Māori health across the two DHBs is now merged as is Pacific health. During 2013-14, more Planning and Funding activity will be joined where this can improve health outcomes and improve service delivery. In some cases collaboration across the two DHBs will also achieve economies of scale.

Our local population

Increased demand on our services is due to population growth, an ageing population and patients with multiple conditions. District health boards face increased expectations from patients and family/whānau re outcomes, and from the government regarding value for money. In response we focus on patient flow, productivity, demand management and getting the best possible patient outcomes across our whole system.

Board priorities

The 2013 strategic priorities for Auckland District Health Board's management (executive and clinical) are based on underpinning principles:

- That management ensures all our services are delivered in a way that is safe and of high quality (technical and delivery quality)
- That management ensures all work environments meet health and safety requirements.

The Board requires a very clear emphasis (as well as urgency and determination) be placed on the critical strategic priority –"Getting Our House in Order" while also initiating work on the strategic priority – New Models of Care.

1. "Getting Our house in Order"
   i. Being clear who we are, what we do and how we do it
      - Coherent organisational structure
      - Renewal of purpose and values
      - Clarity of goals and objectives
      - Balanced approach across provider and population
      - Strengthen and embed clinical leadership
   ii. Demonstrating delivery
      - Culture of accountability at all levels of the organisation (including working within delegated authorities and organisation policies)
      - Meet all performance targets, including all national health targets and whole-of-government key result areas
      - Meet all financial budgets (provider and funder)
      - Coherent operational productivity and quality programmes
   iii. The right staff with the right skills in the right place
      - Culture of caring and compassion
      - Strategic approach to human resources
      - Enhanced learning and development
      - Alter skill mix and skill distribution
   iv. Ensuring a solid financial foundation
      - Proactive and rigorous management of risk
      - Financial discipline across every part of the organisation
      - Defensible budgets
      - Sound cost reduction programmes
   v. Secure a stable IT platform
      - Secure IT business continuity (particular emphasis on clinical systems)
   vi. Service Priorities
      - Starship - complete the business case for next phase of development
      - Introduce productivity based models for elective surgical services
   vii. Working with Partners to deliver
      - Enhance collaboration with Waitemata DHB, Northern region DHBs, healthAlliance, Health Benefits Limited, Health Workforce NZ and the Health Quality and Safety Commission

2. New Models of Care
   i. Empowering patients
      - Self Directed Care
      - Improving education and information
      - Greater emphasis on preventative care
      - Greater involvement of family
      - Advance Care Planning

ii. Targeting interventions to deliver real improvements
    - Address health inequalities (especially Māori and Pacific) with specific and focused initiatives

iii. Closer working across the health system
    - Enhanced relationship and action orientated initiatives with Primary Care (including PHOs), Whānau Ora providers, NGO providers and private providers
    - Integrated care (meaningful communication, structured clinical handover, shared pathways and shared services) - between services within hospital, between hospital and community services (including NGOs), between hospital and primary care, between hospitals, between District Health Boards, between health sector and other sectors and between Auckland DHB and St John Ambulance
    - Reduction in unplanned and unnecessary hospital admissions

iv. Increasing accessibility to care
    - Localities-based delivery of care
    - Shorter waits for acute and elective services
    - Integrated after-hours care

v. Improving the effectiveness of services
    - Improved health of older people (single point of service entry wherever possible, improved stroke and dementia care, enhanced culture of care for older people across all providers including rest home and residential care)
    - Improved health of children (implement model of care that flows from Starship and Children's Health planning process as well as bilateral child health plan formed between Auckland and Waitemata District Health Board)

The new models of care described above will empower people to take more control of their health and wellbeing and will maximise quality of life. This will be a radical change for patients and health providers. As a result the relationship between different health providers as well as the contract between the public and health care providers is likely to change.

Service design starts with an understanding of what is important to people. Services respond by being free-flowing, i.e. being based on patient need and oriented to the outcomes people want for themselves and for their communities.

Locality work will continue to build integrated services in Wards of the city. Keeping things local helps to address the social determinants of health and it improves health outcomes. Working at a local level will ensure we address areas of inequity. This will ultimately reduce inequalities in health outcomes across population groups.

In 2013-14 we will prevent early death, long term illness and distress via key programmes addressing:

- Cardiovascular disease
- Cancer
- Obesity
- Diabetes
- Mental health problems
- Alcohol related harm

Further detail on these and other priority activities is includes in module 3.

The factors influencing DHB priorities

Government policy	Better, sooner, more convenient health services		
Ministry's outcome objectives (National)	Health services are clinically integrated, more convenient and people-centred Service integration	New Zealanders are healthier and more independent	Future sustainability of the health system is assured Regional collaboration Value for money
Health targets (National)	Emergency Departments Elective surgery Faster Cancer treatment	Immunisation Help to quit smoking More heart and diabetes checks	
Other govt priorities (National)	Reduce rheumatic fever Clinical integration Access to diagnostics Mental Health service development plan	Prime Minister's youth mental health project White paper on vulnerable children Whanau Ora	Living within our means
Vision (Regional)	Improve health outcomes and reduce disparities via better, sooner, more convenient services We will do this in a way that meets future demand whilst living within our means		
Goals (Regional)	Patient Experience Aiming for zero patient harm Performance improvement	Population Health Adding to and increasing the productive life of people in the northern region	Cost/Productivity Region's health resources sustainably managed to meet present and future health needs
ADHB approach (Local)	Self Directed Care		
ADHB Goals (Local)	Performance Improvement	Lift the health of people living in Auckland DHB	Live within our means
Shared Board priorities ADHB and WDHB (Local)	New models of care		Getting our house in order
	Empowering patients Targeting interventions to deliver real improvements Closer working across the health system Increasing accessibility to care Improving the effectiveness of services		Being clear who we are, what we do and how we do it Demonstrating delivery The right staff with the right skills in the right place Ensuring a solid financial foundation Secure a stable IT platform Service priorities Working with partners to deliver
Localities approach (Local)	Localities work		
	Working within Wards of the city to determine the priorities for local communities		

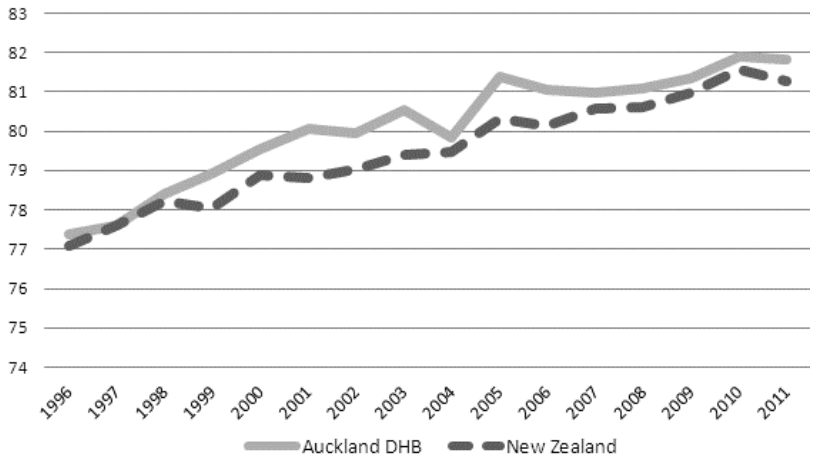
2.3 Key Impacts and Measures of Performance

Key high level financial and non-financial performance measures track our progress. While progress in these areas is not generally seen within one year, we expect to see an impact or improvement over the medium-term.

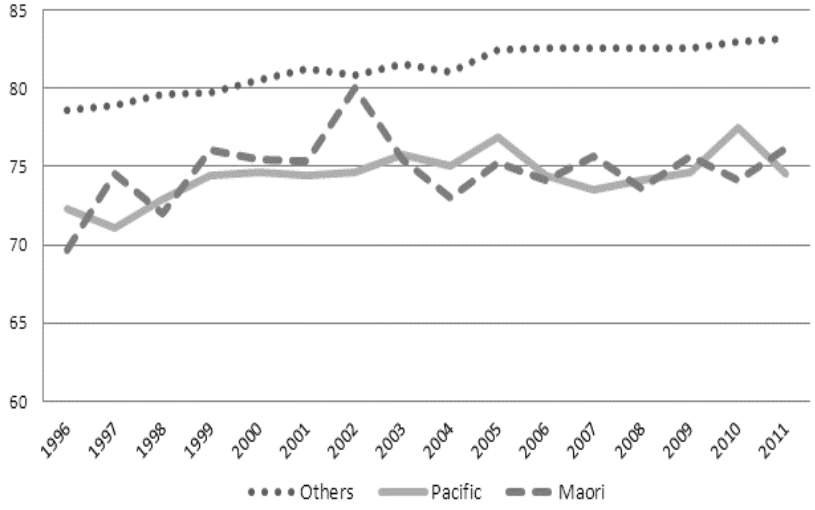
For 2013-14 the focus is on achieving national health targets and improving service integration. These are key areas which contribute to the achievement of improved population health. The overarching goal for the northern region is to 'improve health outcomes and reduce disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means'.

Increased life expectancy Average annual increase in life expectancy at birth	Life expectancy is recognised internationally as a measure of population health status. We expect to see the continued increase of around three years each decade. For New Zealand as a whole, the trend has been 2.8 years per decade over the last 15 years. In 2011 life expectancy in the Auckland DHB area was approximately 82 years.

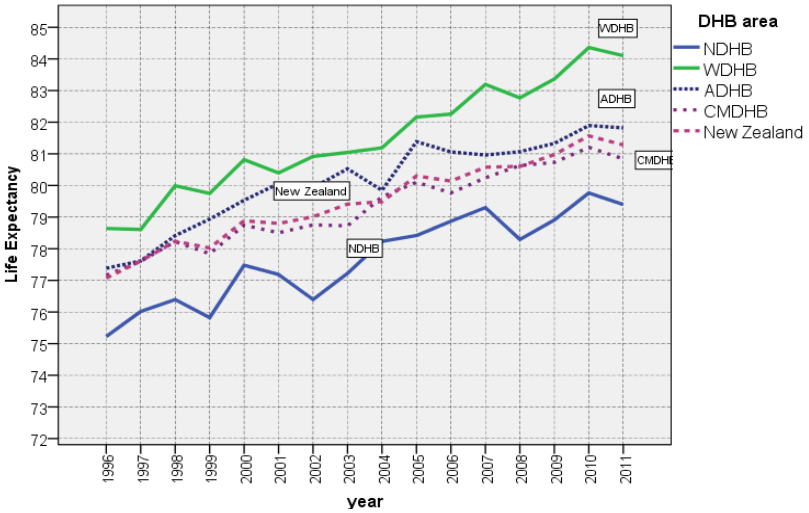
Trend in life expectancy at birth, Auckland DHB and New Zealand



Trend in life expectancy at birth by ethnicity, Auckland DHB



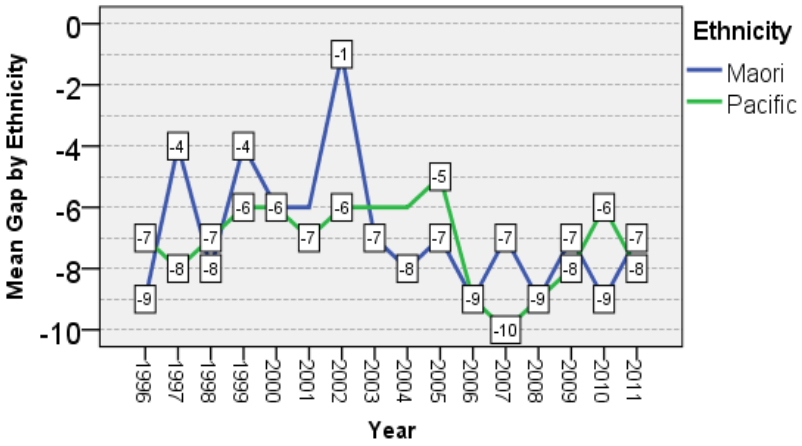
Trend in life expectancy at birth by district health board



If the mortality rate and all the other conditions that impact on life expectancy remain stable, our DHB life expectancy is expected to be 82.2 (SD 0.2) in year 2016.

Reduced inequalities (measured by the life expectancy gap)

There are significant differences in life expectancy rates between ethnic groups within our district. Māori and for Pacific people have lower rates compared to other New Zealanders, with a gap of 7 years for Māori, and 8 years for Pacific. These unacceptable differences in life expectancy rates require focused activities. The gap must be reduced to zero in the long term and requires working with other sectors.



Our target to 2016 is to reduce this gap in life expectancy for Māori and for Pacific compared to Others.

The same targets are used across all groups because all New Zealanders should receive the same level of care and service regardless of ethnicity.

For 2013–16, we have the following main measures for **improved population health:**

Outcome	Medium Term Impact and Rationale	Main Impact Measures
Prevalence of diabetes and cardiovascular disease Over 800 Auckland residents die of ischaemic heart disease, stroke and diabetes every year. Of these, just over 170 are avoidable mortalities. Cardiovascular disease when present with diabetes compounds the clinical risk for people, increasing the likelihood of health problems. 'More Heart and Diabetes Checks' is one of the top six health targets for the country. We will make sure that eligible people receive a risk assessment for cardiovascular disease and treatment for clinical risk factors. This work will minimise complications arising from cardiovascular disease and diabetes. We improve health and independence by making sure people receive assessments on time and have their conditions managed appropriately.	Activities to support this include: • services for chronic conditions provide evidence-based care and are linked to existing strategies • improve long term conditions (particularly CVD and diabetes) services within general practice. Primary and secondary care will be better integrated • identify key secondary care services to support CVD assessment and management i.e. diabetes service • Māori and Pacific providers link with existing services such as Te Hononga Whānau Ora Long Term Conditions Co-ordinators • PHOs will use cardiovascular risk assessment and management services to ensure general practices assess 90% of their eligible populations • Northern Region Cardiovascular Risk Register to improve more heart and diabetes check rates across the district • workforce development through promoting the new online programme by the NZ Society for the Study of Diabetes • addition of diabetes self management support delivered for Pacific communities via the Healthy Village Action Zone	90% of the eligible population will have had their cardiovascular risk assessed in the last five years
Vaccine preventable childhood disease incidence A health system that functions well: • immunises children on time through streamlined systems for registering newborns on the National Immunisation Register (NIR) • provides accessible immunisation services that suit different population groups • intervenes early in life to reduce unnecessary suffering, provide	Actions to achieve improved immunisation include: • monitor rate of newborns enrolled on the National Immunisation Register at birth • help GP practices with overdue vaccination episodes • systems in place to support opportunistic immunisation • communication sharing across services, healthcare providers, and other Government Departments for at-risk	Children fully immunised at 8 months: 90% in 2013-14, 95% by 31st December 2014 (maintain this through to 30 June 2017) 85% of 6 week immunisations are completed 95% of 2 year immunisations are completed Improve the immunisation rates for Māori and Pacific

Outcome	Medium Term Impact and Rationale	Main Impact Measures
better long term prognosis, and better cost efficiency • supports parents to make immunisation decisions through a well-trained, confident and trusted workforce • integrates across social sector services as well as primary and community care • never misses an opportunity to immunise an infant who is overdue for an immunisation This reduces the number of vaccine-preventable diseases amongst Auckland DHB children. We also work to reduce inequalities in immunisation rates between population groups in our community, particularly Māori.	infants/whānau • Outreach Services (OIS) to improve immunisation rates • regular monitoring of ethnicity data collection and collation • Child Emergency Departments and Paediatric Wards immunisation processes improvement plan implemented • work with practices with high numbers of Māori and Pacific children to increase immunisations rates .	children Standardised hospital discharge rate for vaccine preventable childhood diseases
Cancer incidence and survival Cancer is responsible for almost 1 in every 3 deaths of our residents. Earlier access to treatment improves the chances of survival. Shorter waits for consultation, diagnostic services and treatment, at every stage in the patient journey, contribute to better outcomes for patients. Better care coordination and patient navigation can contribute to this goal, especially for our more vulnerable groups. We will improve the patient experience through better care coordination, particularly for Māori and Pacific patients. This means increasing our cervical screening coverage for Māori, Pacific and Asian women. We also need to increase access to bone marrow transplantation for patients with haematological malignancies.	Activities to support this include: • service redesign based on information collected by Faster Cancer Tracking • improve colonoscopy waiting times, clear the waiting list, improve processes and productivity, and increase room capacity • tele-health for multi-disciplinary meetings and administrative support • prioritised National Tumour Standards, including audit of the local lung tumour stream pathway • 3.5 cancer coordinators in place along with a Clinical Lead at a local level • re-design cancer multidisciplinary meetings consistent with national standardised processes • care co-ordination initiatives (cancer care coordinator and pathway tracker) are embedded, informative and productive	Everyone needing radiation or chemotherapy treatment will have this within four weeks. Improvements in cancer services Reducing the equity gap for Māori and Pacific peoples
Access to elective surgery Timely access to elective surgery supports people in our community	Our activities for 2013-14 focus on surgical throughput and wait times • improve intervention rates for	Increase the volume of elective surgery by delivering 13,499 elective

Outcome	Medium Term Impact and Rationale	Main Impact Measures
to live longer, healthier and more independent lives. Elective surgery increases people's functioning because it remedies or improves disabling conditions. We need to meet Government and community expectations regarding: • elective surgery health target discharge volumes • outpatient and inpatient waiting list targets • population intervention rates for hips, knees, cataracts and cardiac surgery We need to streamline processes and make the patient's journey more convenient and timely. We need to deliver elective surgical volumes that: • Improve the intervention rates for the Auckland DHB population • Support our Inter District Flow DHBs • Reduce wait times	the Auckland DHB population • support our Inter District Flow DHBs • reduce wait times • work with the Ministry of Health to encourage collection of surgical intervention rates by ethnicity • collect ethnicity data on patients receiving bariatric and major joint replacement surgery 4 project streams: 3 that redesign patient electives pathways, and 1 designs elective resource management tools and processes: • Orthopaedic patient pathway: enhanced recovery after surgery and initiatives to improve outpatient performance and reduce length of stay • Otorhinolaryngology (ORL) patient pathway: improved scoring tools, reduced outpatient follow ups, shifting work from the operating theatre to an outpatient clinic setting • Ophthalmology patient pathway: improve outpatient performance and make better use of available Senior Medical Officers • improve routines across elective and acute volumes; improve rostering, scheduling and booking; operations hub that improves resource coordination across the hospital each day	surgical discharges in 2013-14
Access to appropriate acute care Less time spent waiting and receiving treatment in the Emergency Department not only gives patients a more dignified and convenient experience when they are acutely ill, but also leads to better outcomes. Less time in the Emergency Department enables us to use our resources more effectively and efficiently. This national health target measures	Some activities to support this (across and adult and children's health) include: • tools and routines that minimise bed block issues • a district nursing model to provide options for urgent care • alternatives to transporting patients including acute referrals for district nursing • community transition activities to support Length of Stay reductions and reduce avoidable admissions	95% of patients will be admitted, discharged or transferred from the Emergency Department within 6 hours

Outcome	Medium Term Impact and Rationale	Main Impact Measures
the efficiency of flow of acute patients through the hospital and into the community. It provides a whole of system view of the organisation including primary and secondary service delivery.	in Emergency Departments • Primary Options for Acute Care: investments for IV in Aged Related Residential Care • reduce falls and pressure injuries in Aged Related Residential Care facilities and reduce hospital admissions	
Reducing Inequities There are unacceptable differences in health status between different groups living in the Auckland DHB area, hence our focus on inequities. Those living with most deprivation have poorer health, shorter life expectancy, and are more likely to be admitted to hospital with avoidable problems, (e.g. which could be better managed in primary care). Our activities to re-dress inequities focus on Māori, Pacific peoples, and new migrant/refugee communities. Auckland DHB works with other agencies and sectors where a joint sector approach can get results. The Regional Public Health Service is engaged in this area, and influences public policy across the region. Our Māori Health Team is engaged with the Whānau Ora programme of work.	Activities include Whānau Ora work • co-location activity and increased integration between the DHB and community-based providers • explore link between multiple readmissions of older Māori and whānau ora assessment and referral from secondary care back to primary care whānau ora providers • work with the Whānau Ora collectives to integrate their health contracts and align these to the Whānau Ora Outcomes Framework • HealthStat roll out implemented. Review Practice Management Systems and programmes for better preventative care at a practice level for whānau ora providers • Healthy Village Action Zone work will continue within the Pacific churches to improve Pacific health • increase cardiovascular and diabetes risk assessments for Asians, migrants and refugees, via general practice and inpatient services • work with local government and other sector on projects oriented to groups with the highest need/deprivation e.g. homeless project	We measure health disparity in our population health data and in service use data. This is tracked over the longer term in recognition that addressing inequity takes sustained long term effort. Inequalities in health outcome should not continue. We expect the same health outcomes for all ethnic groups in the future. Therefore our ethnicity targets are the same as for our total population. All New Zealanders should receive the same level of care and service regardless of ethnicity.
Smoking prevalence Smoking is the single most modifiable risk factor causing disease and death in our community. This is particularly so	Activities include: • smokefree activity and services for Māori , Pacific and pregnant women as priority populations • work with ProCare and the	90% of patients who smoke and are seen by a health practitioner in primary care,

Outcome	Medium Term Impact and Rationale	Main Impact Measures
for Māori and Pacific, resulting in a significant reduction of quality of life and years of life. New Zealand also has relatively high rates of smoking in pregnancy. Reducing smoking rates leads to better maternity and neonatal outcomes. Providing brief advice to smokers has been shown to increase their chances of making a quit attempt. More quit attempts will lead to a reduction in both smoking rates and smoking related diseases.	National Hauora Coalition to reduce the smoking rate, by offering brief advice and cessation support • facilitate smokefree training for community based health professionals e.g. dentists, lead maternity carers • Smokefree Pregnancy Facilitators provide help to pregnant women who want to stop smoking • Smokefree Services to help departments to reach and sustain the health targets	*and* 95% in public hospitals, are offered brief advice and support to quit smoking Progress towards 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit
Service Integration We need to plan services for local communities and understand the patient journey through our services. Integration improves patient outcomes and experience because services are delivered in the right place at the right time. Integration addresses the demands on health care and depends on clinicians working together right across the health system.	We will do more to integrate community, primary care, and secondary care health services. Activities include: • delivering new models of care from community settings through Integrated Family Health Networks • support primary care to deliver free under 6's after-hours care and primary options for acute care volumes • specialist gerontology support to aged residential care to better support older people living in the community • implementation of agreed clinical pathways	95% of the metro-Auckland population can access free after-hours care for children under six years of age 10% reduction in aged care facility clients presenting to our Emergency Departments

During 2013-14 we will develop metrics, targets and a reporting process to support our commitment to Self Directed Care. The metrics will include process measures, intermediate and long term outcome measures.

Improving patient safety and experience

Health and disability services need to be safe and of high quality. People who use our services should have a high level of trust and confidence in the health system and rate their experiences positively. More family-friendly initiatives are in place to make patients feel safe and supported while in hospital. Patient safety influences the confidence patients have in the health system. Safe practice contributes to health gain by securing good outcomes for patients and by extending the length and quality of a patient's life.

For 2013–16, we have the following main measures for **Improving patient safety and experience**

Outcomes	Medium Term Impact	Main Measures
Patient experience Putting patients and community at the centre ensures we deliver the best care. We earn the trust placed in us by our community by insisting on quality and striving to get the basics right first time, every time. Service are made safer when patients, their families / whānau, and communities are involved in their design and delivery. Patient and family involvement also improves health outcomes and satisfaction while decreasing costs.	Strategies to deliver these: • participate in the Health Quality and Safety Commission's programmes • patient and Family-Centred programme implemented • pilot 'Care Partner' agreements • service improvements in Cardiology transition • re-design of Hospital 'front door' and improve way-finding • open-disclosure policy for all major adverse events • more patients attending ambulatory services receive a copy of their clinic letter	40% reduction in Central Line Acquired Bacteriaemia in intensive care units 90% of respondents in the Patient Experience Survey rate their overall experience as 'Very Good' or 'Excellent' (increase from 82%) Reduce post discharge follow-up attendances at hospital by approximately 10%
Quality and Safety Patients and families need to be confident of the quality and safety of the care they will receive. And know that the care they receive is best practice and evidence-based.	Improve quality and safety by: • the regional 'First do no harm' programme • service improvement eg patient flow project • being open and transparent by publishing our quality accounts alongside our annual report • Advance Care Planning for people who are approaching end of life	The impact of quality initiatives is monitored through: Reduced adverse clinical events Reduced falls in hospitals Reduced medication errors Reduced patient readmissions Reduced hospital infection rates

The DHB also reports on our **financial performance**. DHB health resources must be managed efficiently and sustainably in order to meet present and future health needs. We need to demonstrate financial responsibility, covering all costs from our annual income. We will remain a sustainable organisation which manages its resources efficiently and achieves a break-even position each year.

Further detail on the activities planned for 2013-14 and how we measure their progress is contained in module 3.

MODULE 3: Targets and Priorities

Modules three and four cover DHB actions for 2013-14 that achieve national, regional and local priorities. These are areas of new or amplified activity and do not cover all our business as usual. Some of our business as usual activity is included in module five as part of our statement of forecast service performance.

3.1 Prime Minister's Youth Mental Health Project

What are we trying to do?

Improve young people's mental health and wellbeing through more accessible and appropriate services, particularly through enhanced school-based services and an alliance between the parties: the DHB, schools and relevant PHOs.

Why is this important for community and patients?

A significant number of young people experience mental health problems during adolescence. These and other health issues can have life-long consequences. Young people often experience barriers to accessing healthcare which need to be addressed through service design.

Progress to date

- Nurse-led services are provided in all six decile 1-3 schools, another three mainstream schools, eight Alternative Education settings, and one Teen Parent Unit
- All nurses in these schools have, or are working towards, a post graduate qualification in youth health and have undertaken HEADSS training
- Nearly 9000 young people in Auckland have increased access to primary health services through the school-based health service programme
- Through these services, 94.7% of Year 9 students in the mainstream programme received a comprehensive wellness check (HEADSS) in 2012
- Three schools have access to GP services in school

How are we going to do it? (Key planning approach)

- Establish an appropriately structured youth alliance with partner schools, the DHB and PHOs with the aim of better meeting young people's health needs in schools and across the healthcare system
- Establish appropriate alliance governance and clinical governance structures which will provide oversight of the quality of referrals to community and secondary services, particularly mental health and addiction services
- Enhance the school-based health service programme particularly through the addition of general practitioner services in schools and through greater access to

primary mental health services. This may require shifting some resources from adult primary mental health to target youth more effectively

- Ensure GP providers in the enhanced schools programme receive 'Comprehensive Wellness Check (HEADSS)' training, and extend the use of this tool within their own practices
- All nurses in the enhanced schools programme will maintain skills in HEADSS. New nurses will receive HEADSS training. Other health professionals may also be supported to undertake HEADSS training
- Ensure a range of psychological services are available to young people including e-therapy (once determined by the Ministry)
- Extend the comprehensive wellness checks (HEADSS) to more high risk young people in schools within the Auckland DHB programme, specifically young people who are new to a school or are facing significant disciplinary action

Specific deliverables. Actions to deliver improved performance

- A Youth alliance agreement is in place by August 2013
- Appropriate youth alliance governance structures are initiated by August 2013
- Build mental health capacity in primary care through a Youth Alliance which has been established between the DHB, PHOs and schools. The DHB will enter into a head agreement with a PHO to administer the Youth Alliance. The Youth Alliance will:
    - provide access to primary mental health services in the community inclusive of stepped care provided by Youthline and other PHO managed psychological services, increasing access to the primary mental health service for all youth regardless of PHO enrolment
    - improve access to primary mental health services through the use of extended GP consultations in schools, provision of an e-therapy (once available) in schools and Alternative Education settings, and increased access to off-site psychological services
    - train GPs to work in schools and reflect this practice in their home practices
    - establish a clinical governance group to provide oversight of referrals to other community and secondary services, particularly mental health and alcohol and drug services
- No co-payment charged for the primary mental health service for any youth aged 12 to 19 years (inclusive)
- Systems to assure the quality of referrals to community and secondary services, particularly mental health and addiction services are endorsed by the Clinical Governance Group and are in place by June 2014
- Review primary mental health services including Youthline's services to ensure models of delivery are appropriate, in line with the stepped care model, and are provided to more young people by June 2014
- At least ten GPs have received HEADSS training by November 2013
- An e-therapy tool is available to young people through the enhanced schools programme from August 2013

- Use of the e-therapy tool is being promoted through GP clinics within the Youth alliance by December 2013 and in other GP clinics by June 2014
- More high risk students receive a HEADSS assessment
- Stocktake of primary and community (primary) mental health services is undertaken by December 2013 including a gap analysis and proposed actions to address gaps. Relevant local providers are consulted on findings before the stocktake, analysis and actions are finalised. The stocktake includes NGO providers and drop in centres.
- Systems to improve Child and Adolescent Mental Health and Alcohol and Other Drugs (AOD) follow-up care are developed including approaches to data collection and information on the number of young people discharged with a follow-up care plan in place

How will we know we've achieved it?

- The Youth alliance has established effective governance arrangements by June 2014
- 95% of Year 9 students in the enhanced schools based health services programme received a HEADSS Assessment during 2013, and equity of access for Māori and for Pacific young people is achieved
- Each school has an associated GP providing a school clinic for at least 4 hours per full time nurse
- 20 'high risk' students received a HEADSS Assessment in 2013
- At least 20% more young people access primary mental health services in 2013-14 than in 2012-2013. (Baseline for 2011-12 is estimated at 225. Based on this, an estimated 45 more young people will access primary mental health services in 2013-2014 compared with 2012-2013)
- Stocktake of primary mental health service in the community including gap analysis is produced by December 2013 (The stocktake includes NGO providers and drop in centres).
- Baseline data on the number of young people with a Child and Adolescent Mental Health and Alcohol and Other Drugs (AOD) follow-up care plan is established by June 2014.

3.2 Maternal and Child Health

Better Public Services: Supporting Vulnerable Children

3.2.1 Increased Immunisation

What are we trying to do?

Improve the health and wellbeing of children in Auckland DHB through achieving the immunisation health target – children fully immunised at 8 months (85% in 2012-13, 90% in 2013-14, 95% by 31st December 2014, and maintain this through to 30 June 2017).

Why is this important for community and patients?

A health system that functions well for immunisation is one that:

- Immunises children on time through streamlined systems for registering newborns on the National Immunisation Register (NIR) and provides accessible, quality immunisation services that suit different population groups
- Intervenes early in life in order to reduce unnecessary suffering, provide better long term prognosis and better cost efficiency
- Supports parents to make immunisation decisions through a well-trained, confident and trusted workforce

Progress to date

Auckland DHBs exceeded the 2012-13 target of 85% of children fully immunised at 8 months, reaching 91% to the end of December 2012. Additionally, the equity gap between population groups has reduced. This has been accomplished through increasing knowledge and awareness of immunisation guidelines and providing support for midwives and general practice staff as well as developing robust referral processes to Outreach Services and a strong and experienced steering group.

An improved ability to consistently identify overdue children in a timely manner has also impacted positively on performance.

How are we going to do it? (Key planning approach)

- Ensure that the Auckland and Waitemata DHB combined immunisation steering and operational groups are representative of both DHBs and functioning well
- Work with the Primary Health Care team to increase newborn enrolment rates
- Compare the birth registers with the National Immunisation Register (NIR) birth cohort and monitor rate of newborns enrolled on the National Immunisation Register at birth
- Identify and work with practices with overdue vaccination episodes to improve timeliness
- Review and improve inpatient and emergency department immunisation information and ensure systems are in place to support opportunistic immunisation
- Support communication sharing across services, healthcare providers, and other Government Departments for at-risk infants/whānau
- Continue to fund Outreach Services (OIS) to improve immunisation rates
- Develop and embed joint National Immunisation Register / Outreach Services Waitemata and Auckland DHBs service delivery model
- Maintain regular monitoring of ethnicity data collection and collation

Specific actions to deliver improved performance

- Combined steering groups are fully operational by 1 July 2013
- Quarterly practice level coverage reports will be produced from the National Immunisation Register and 95% of practices will be undertaking monthly internal audits on not fully immunised children by 30 June 2014

- Child Emergency Departments and Paediatric Wards immunisation processes improvement plan implemented and consolidated by 30 June 2014
- We will work individually with practices with high numbers of Māori and Pacific children enrolled to increase immunisations rates within these groups so that the equity gap for the 8 month immunisation coverage rate is reduced by 75% by 30 June 2014
- We will standardise across Waitemata and Auckland DHBs a PHO reporting system by 30 June 2014 for those practices that have a large number of children on overdue reports
- Develop and implement a 2014 immunisation week plan by April 2014
- Monitor the 6 week immunisation completion rates quarterly
- Work with the Ministry of Health to develop processes to access identifiable practice level information by 31 December 2013
- We will continue to work with other sectors (Ministry of Social Development, Child Youth and Family, Education) and NGOs through the Auckland DHB Child Health Stakeholder Advisory Group and Immunisation Governance Group on strategies for improving immunisation coverage

How will we know we've achieved it? Measured by

- Children fully immunised at 8 months (85% in 2012-13, 90% in 2013-14, 95% by 31st December 2014) (using National Immunisation Register data)
- 95% of newborns are enrolled on the National Immunisation Register at Birth
- 100% of newborns are enrolled with a GP (measured at 6 weeks)
- 85% of 6 week immunisations are completed.

3.2.2 Rheumatic Fever

What are we trying to do?

Reduce the incidence of Rheumatic Fever (RF) by two thirds to 1.4 cases per 100,000 nationally by 2017 –Auckland DHB will reduce to 3.2 by 30 June 2014.

Why is this important for community and patients?

Reducing the incidence of acute rheumatic fever will improve the life expectancy of our populations, particularly Māori and Pacific who are most affected as well as preventing serious cardiac morbidity that is a result of this preventable disease.

Progress to date

Three key geographical areas of risk have been identified within the Auckland DHB region (High/Medium/Low). A phased implementation approach will be undertaken starting with the high risk area in 2013-14 then proceeding to medium/low risk areas over subsequent years by 2017.

A Steering Group has been established with wide intersectoral membership including primary care, Ministry of Social Development, Housing NZ, Education, Council, public health and Māori and Pacific representation.

A funding model is under discussion with the Ministry of Health.

A Project manager has been confirmed to develop and implement the sore throat swabbing programme.

How are we going to do it? (Key planning approach)

- The joint Auckland DHB and Waitemata DHB strategy is focused on high risk areas and Māori and Pacific populations and includes the following approaches;
  - systematic Throat Swabbing – in agreed high risk schools (approximately 15) with exploration of additional venues
  - opportunistic Throat Swabbing
  - housing and related issues
  - disease management and coding
  - primary healthcare response including training of healthcare professionals
  - health literacy / education awareness – we will ensure that all child services including schools and Well Child providers have access to rheumatic fever health promotion resources
- Auckland and Waitemata DHBs will take a similar strategic approaches to achieving a reduction in the incidence of Rheumatic Fever in their areas, however specific approaches will vary as the pattern of disease incidence varies in the two DHBs.
- We will work in collaboration with local housing services and social services to implement actions to provide 'healthy homes' type support where possible to families with children at high risk of developing acute rheumatic fever
- We will ensure that all children with confirmed acute rheumatic fever receive appropriate prophylactic antibiotic treatment
- All children diagnosed with acute rheumatic fever in the last three years in Auckland or Waitemata DHBs will be case reviewed to inform the programme
- Significant event reviews will be undertaken for all future cases of acute rheumatic fever

Specific actions to deliver improved performance

- Ensure all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission by June 2014
- Develop a rheumatic fever prevention plan by 20 October 2013 and implement as agreed with the Ministry of Health
- Sore throat swabbing is implemented in 16 schools within the Auckland district by 30 June 2014
- 95% of GP practices are following the National Heart Foundation Sore Throat Management Guidelines by 30 June 2014
- A process is in place by 30 June 2014 that ensures people identified through the sore throat swabbing programme with Group A Streptococcal infections receive appropriate treatment within 7 days of being symptomatic

- A process is in place by 30 June 2014 to ensure that all people with a history of rheumatic fever receive monthly antibiotics no more than 5 days after the due date

How will we know we've achieved it? Measured by

- Achieve a 10% reduction on the Auckland DHB current rate of 3.5:100,000 to 3.2 per 100,000 population
- 95% of GP practices are following the National Heart Foundation Sore Throat Management Guidelines by 30 June 2014
- All new cases of acute rheumatic fever are subject to a 'significant event' review.

3.2.3 Children's Action Plan Implementation

What are we trying to do?

Support the prevention and early identification of child maltreatment through delivering on the Children's Action Plan (CAP), and through other initiatives.

Why is this important for community and patients?

Actions taken within the health sector will help improve outcomes for vulnerable children and contribute to a reduction in the number of child assaults (which supports the Prime Minister's Better Public Services key result area for vulnerable children).

Progress to date

- Auckland DHB is a leading DHB in managing programme implementation for both partner abuse and child abuse and neglect components
- The National Child Protection Alert system has been implemented and a comprehensive Family Violence Prevention and Intervention programme is in place which works across primary and secondary care
- Auckland DHB took a leading role in developing and implementing the Gateway Assessment programme for children and young people in state care
- We have developed the Shaken Baby Prevention programme and host the National Coordinator
- We are a signatory to the Memorandum of Understanding with Child Youth and Family (CYF), Police and DHBs and host CYF-funded liaison social workers
- A Vulnerable Pregnant Women's Group is in place
- We have a Child Youth and Family -funded Liaison social worker in place within the hospital services
- A training programme for staff in child health services, and primary care to recognise signs of child maltreatment is in place

How are we going to do it? (Key planning approach)

- Keep informed of developments in the Children's Teams demonstration sites and provide advice and support as needed

- Commence service and development planning so that a continuum of services across primary and referred health services are well positioned to meet the needs of vulnerable pregnant women, children and families
- Establish an Auckland wide intersectoral Children's Better Public Service target Steering Group based on the existing Auckland DHB Child Health Stakeholder Advisory Group

Specific actions to deliver improved performance

- The governance structure for the Auckland DHB Family Violence prevention and intervention programme will be further developed to ensure alignment with the Children's Action Plan once further information is available, by 30 June 2014
- Extend current training of DHB professionals to recognise signs of maltreatment, for staff in the following key services: Sexual Health and Emergency Departments - agreed by 30 September 2013 and a phased implementation underway by 30 June 2014
- Policies and reporting systems to recognise and report child abuse and neglect are reviewed by 30 June 2014
- Planning for implementation of the Children's Action Plan will ensure that activities and outcomes are aligned with the Auckland DHB Child and Youth Mental Health Action Plan which in turn aligns with the Mental Health Service Development Plan and 'Healthy Beginnings'
- The Auckland DHB Child and Youth Mental Health Action Plan includes specialist services targeting high need families/whānau with vulnerable infants
- Planning for services to support vulnerable children will ensure effective linkages with the existing Auckland DHB Children of Parents with Mental Illness and Addictions (COPMIA) programme.

3.2.4 Maternal and Child Health

What are we trying to do?

Reduce inequalities, improve the health, well-being and outcomes for women, babies and infants in Auckland DHB through integrated, evidence-based maternity and children's services and through effective collaboration with other agencies.

Why is this important for community and patients?

The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. Healthy children lead to healthy adults. The health outcomes for newborns and mothers are vital to this.

Disparities in outcomes for pregnant women and children are associated with later engagement with health professionals, higher smoking rates during pregnancy and higher rates of obesity amongst other factors. Earlier access to a range of health advice, information and interventions can improve health outcomes for pregnant women and

their children. The quality of the interface between maternity carers and other primary healthcare professionals supports these aims.

While many families living in Auckland and Waitemata have better health than their national counterparts, some remain significantly disadvantaged. Māori and Pacific children have poorer health status than other groups. Strategies to improve health and wellbeing need to take a holistic approach involving a wide variety of stakeholders, incorporating safety, education and improved access to primary care and specialist services.

Progress to date

- A joint Waitemata DHB and Auckland DHB Child Health Improvement Plan 2012-2017 has been completed with input from Primary Health Care, Lead Maternity Carers, NGOs and sectors such as housing, education and Social Development
- A maternity services collaboration process between Waitemata and Auckland DHBs has recently commenced. This will define a high level strategic direction regarding future maternity service provision across the two DHBs
- Maternity Quality and Safety Programme Plans have been signed off by the Ministry of Health and agreed actions are being implemented
- Activity in the Auckland DHB Oral Health Business Case has been achieved. This included provision for a total of 6, level one diagnostic mobile dental units and a total of 14 children's community dental facilities. The facilities included 13 new fixed clinics and one existing clinic refurbishment. All mobile vans and fixed sites are being utilised for service and are now fully operational
- Agreement has been reached that the Auckland DHB Child Health Stakeholder Advisory Group becomes an Auckland-wide DHB forum with a focus on the child Better Public Service targets – Rheumatic Fever, Immunisation, Early Childhood Education and implementation of the Children's Action Plan
- Auckland DHB is actively participating in a regional Child Health Network in order to achieve Regional Child Health Plan objectives
- The majority of Auckland DHB's Oral Health Business Cases planned activity was completed during 2012-13
- The B4 School Checks Service Alliance is working well and Auckland DHB is close to achieving Ministry of Health targets for the first time

How are we going to do it? (Key planning approach)

- Work collaboratively with other DHBs to plan maternity services that better meet the needs of women across the Auckland region
- Implement agreed changes to the Auckland DHB Child Health Stakeholder Advisory Group to form an Auckland-wide intersectoral forum which supports the delivery of child related Better Public Service targets
- With a particular emphasis on Māori and Pacific populations and young pregnant women, work with primary care, maternity, and Well Child providers to improve integration, continuity of care and seamless transitions between services through:

  - increasing the number of women who register with a Lead Maternity Carer by week 12 of their pregnancy
  - developing systems and an action plan that considers health promotion about the importance of pregnant women engaging with primary care, to ensure every pregnant woman is enrolled with a PHO and registered with a GP
  - enabling clinicians to support pregnant women who smoke to quit
  - ensuring as close as possible to 100% of under-sixes have access to free after hours primary care
- Implement the 2013-14 action plan for the Regional Child Health Plan focusing on the agreed child health priorities: Sudden Unexplained Death in Infancy, childhood injury, lower respiratory tract disease, Rheumatic Fever and skin sepsis
- Work with primary care to provide integrated child health services in the right place at the right time
- Use the National Maternity Clinical Indicators developed by the Ministry and other data to monitor and benchmark maternal and neonatal outcomes
- Review pregnancy and parenting education in line with Ministry of Health specifications (to be released), with a view to improving access for vulnerable women and whānau
- Continuity of care pathways for Māori , Pacific and young pregnant women
- Improve access to maternal/perinatal mental health services for pregnant and postpartum women
- Review and improve handover of mother and baby as they move through the maternity and primary system
  - review electronic referral systems between maternity services, NIR, primary care, Well Child Tamariki Ora provider, newborn hearing screening and oral health by 30 September 2013
  - gap analysis and develop a quality improvement plan by 31 December 2013
  - implement the quality improvement plan from 1 January 2014 and review progress by 30 June 2014
- Work with both primary and secondary care providers to utilise all opportunities for connecting with children and families to raise awareness of the importance of early childhood education
- Improve B4 School Check cover, programme quality and service referral pathways
- Improve access to and referral acceptance timeliness for Well Child/Tamariki Ora services
- Improve access to child health specialist services.

Specific actions to deliver improved performance

Maternity/Child/ Well Child/Tamariki handover

- Collate baseline data by March 2014 for:
  - Pregnant women (by ethnicity) registered with a Lead Maternity Carer by 12 wks
  - Pregnant women enrolled/registered with a PHO/GP
  - Referrals to Well Child/Tamariki Ora providers

- Implement the revised Ministry of Health Pregnancy and Parenting service specifications (under development by Ministry of Health) through a request for proposals process to provide more effectively targeted pregnancy and parenting services from March 2014
- Renew the Baby Friendly Hospital Initiative (BFHI) accreditation at ACH as the vehicle to support women to fully and exclusively breastfeed
- Work towards obtaining data for all infants on breast-feeding rates, including those fully and exclusively breastfed at 6months
- Develop and implement a process to support maternal/perinatal mental health services screening of pregnant and postpartum women who access provider arm services for antenatal and post natal care
- Develop a system to support direct Lead Maternity Carer referral to primary mental health services - by June 2014
- Deliver messages on Facebook and through existing Pacific networks to inform women of the importance of booking early with a Lead Maternity Carer
- A Pacific Midwifery Advisor is in post by August 2013
- A maternity scorecard is in use by the Clinical Governance Group by June 2014
- An Annual Maternity and Clinical Report for 2012 is published in August 2013 and for 2013 data, in August 2014
- 95% of children will have free access to after-hours care by 30 June 2014
- Develop a draft maternity services plan by June 2014
- Maternity / Primary system handover process improvement plan implemented and consolidated by 30 June 2014
- Ministry of Health targets for B4 School Checks will be met by 30 June 2014
- 95% of 2 year old children are fully immunised by 30 June 2014
- 'Safe sleep' practices are implemented in all Auckland DHB services by 30 June 2014
- Develop a plan to implement the Well Child Tamariki Ora Quality Improvement Framework within six months of the national roll out of the framework
- Key agencies including Well Child providers have implemented the National Safekids Strategy 2013-14 by 30 June 2014

How will we know we've achieved it?

- A draft maternity services plan is approved by June 2014
- Baseline data on the proportion of women (by ethnicity) registered with a Lead Maternity Carer by week 12 of their pregnancy is obtained by March 2014
- Baseline data on the proportion of pregnant women (by ethnicity) enrolled/registered with a PHO is obtained by March 2014
- Providers begin delivering pregnancy and parenting education services in line with new specifications from April 2014
- A maternal/perinatal mental health screening process is developed by June 2014
- Comprehensive data is obtained on breast feeding rates at six months
- At least 90% of all eligible children receive a B4 School Check including at least 90% of children in the areas of highest deprivation

- New Annual Clinical and Maternity Reports are disseminated at an Annual Clinical Report day in August 2013.
  Note: related deliverables can be found in the Better help for smokers to quit and Primary care sections

3.3 Service Development

3.3.1 Shorter Waits for Cancer Treatment

What are we trying to do?

Reduce the rate of disease, premature deaths and reduced health and independence caused by cancer in our community through timely access, diagnosis and treatment for our patients.

Why is this important for community and patients?

In 2012 there were over 300 people newly diagnosed with cancer within our district. To ensure that we achieve better cancer care for everyone we will continue to work collaboratively to reduce waiting times for specialist appointments, diagnostic interventions and treatment times.

We will improve cancer care coordination and enable people who have cancer to maintain control of their care. We are exploring ways of developing capacity and improving the timeliness and quality of care for those people who are diagnosed with cancer.

Progress to date

We continue to work collaboratively within the Auckland Region which ensures that people wait no longer than four weeks for radiotherapy and chemotherapy treatments. We have commenced Faster Cancer Tracking for the 14/31/62 wait day indicators as well as implementing care coordination to meet these indicators.

- We are able to report collated information from Faster Cancer Tracking to the Ministry of Health
- The cancer care coordination team is in the process of being recruited with a lead already in place
- A lead Clinical Director is in place
- Multi-disciplinary meeting requirements are being identified
- Colonoscopy wait times are being actively monitored with plans being put in place to improve times

How are we going to do it? (Key planning approach)

- Collect and use the information collected by Faster Cancer Tracking to review and redesign care activities to ensure a seamless service is provided
- Work with Waitemata DHB to support the bowel screening pilot and implementation of prostate and endoscopy quality improvement plans

- Invest in tele-health for multi-disciplinary meetings and administrative support to maximise the ability for comprehensive attendance at multi-disciplinary meetings and optimise clinical resources (i.e. reduce travelling)
- Establish systems to report percentage of patients receiving a Multi Disciplinary Meeting by tumour stream
- Begin implementing prioritised National Tumour Standards including audit of the local lung tumour stream pathway
- 3.5 Cancer Coordinators working with a Clinical Lead at a local level who will be supported to attend the relevant training and mentoring forums
- Work collaboratively with the Northern Cancer Network to implement national cancer coordination improvements at a regional and local level
- Actively participate in a Regional Prostate Cancer Steering Group

Specific deliverables/Actions to deliver improved performance

- Re-design cancer multidisciplinary meetings consistent with national standardised processes of access, documentation, communication and care coordination
- Care co-ordination initiatives such as cancer care coordinator and pathway tracker roles are embedded, informative and productive

How will we know we've achieved it? Measured by

- All patients, ready for treatment, wait less than four weeks for radiation therapy and chemotherapy from decision to treat. This will be supported through the implementation of our regional radiation oncology plan and linked to the national radiation oncology plan due to be completed at the end of 2013
- Waiting time indicators reported against (waiting times maximum 14 days after referral for high suspicion of cancer; 31 days from decision to treat to treatment or plan; 62 days from referral to treatment or plan)
- Report on the percentages of patients presented to multidisciplinary team meetings starting December 2013, consistent with regional process
- Patient satisfaction high
- All patients requiring bone marrow transplant will have access to services provided at nationally consistent waiting times
- 50% of patients accepted for urgent colonoscopy receive their procedure within 14 days
- 50% of patients accepted for a diagnostic colonoscopy receive their procedure within 42 days
- 50% of patients waiting for a surveillance colonoscopy receive their procedure within 84 days of the planned date.

3.3.2 Improved Access to Elective Surgery

What are we trying to do?

Ensure that we provide our community with timely and equitable access to elective surgery to support our community to live longer, healthier and more independent lives.

Why is this important for community and patients?

Improving people's access to elective surgery starts with patients getting fast access to diagnostics and specialist assessment. We want patients to get the elective surgery they need without having unnecessary waits on booking lists. Patients needing specialist assessment and elective surgery will get this more quickly and through fairer and more transparent decision making. Our activities for 2013-14 focus on surgical throughput and wait times. These activities will help us to achieve the Government and community's expectations and our regional targets for Elective surgical discharges.

How are we going to do this?

We will deliver elective surgical volumes that:

- Improve the intervention rates for the Auckland DHB population
- Support our Inter District Flow DHBs
- Reduce wait times
- Work with the Ministry of Health to encourage collection of surgical intervention rates by ethnicity
- Collect ethnicity data on patients receiving bariatric and major joint replacement surgery

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

- The Orthopaedic patient pathway including enhanced recovery after surgery (ERAS) and outpatient initiatives to improve outpatient performance and reduce length of stay
- The Otorhinolaryngology (ORL) patient pathway including improved scoring tools, reduced outpatient follow ups and shifting work from the operating theatre to an outpatient clinic setting
- The Ophthalmology patient pathway to improve outpatient performance and make better use of available Senior Medical Officer (SMO) resources
- A resource management project, to improve planning routines across elective and acute volumes. It will improve rostering, scheduling and booking to better execute on plan. It will also improve Auckland DHB responsiveness to variations on any given day through an operations hub that improves resource coordination across the hospital each day

Specific deliverables/Actions to deliver improved performance

- Deliver 13,499 elective surgical discharges for the Auckland DHB population

- Comply with the wait time standard of no patients waiting longer than 5 months from referral to First Specialist Assessment (FSA) and progress made towards achieving 4 months
- Comply with the wait time standard of no patients waiting longer than 5 months from First Specialist Assessment to surgical procedure and progress made towards achieving 4 months
- Completion of the above surgical improvement work streams per the Elective Services Workforce and Productivity Programme contract
- Prioritisation of all elective patients for treatment on national, or nationally recognised tools, and treating patients in accordance with assigned priority

How will we know we've achieved it? Measured by

- Delivery against agreed volume schedule, including a minimum of 13,499 elective surgical discharges in 2013-14 towards the Electives Health Target
- Standardised intervention rates met for electives (per 10,000 population): major joint replacement procedures = 21, cataract procedures = 27, cardiac procedures = 6.5.

3.3.3 Cardiac Services

What are we trying to do?

We want clinically appropriate, timely and equitable levels of access across the region to key cardiac assessment services. We want to improve the patient journey from the community through primary, secondary and tertiary care. We will do this by focusing on:

- Improving rates of access and reduce waiting times for patients needing cardiac assessment, diagnostic and treatment services
- Reducing inequalities within our community
- Reducing disease and premature death in our community caused by Cardiac disease
- Managing access to specialist services to ensure that the services are provided to patients with the most capacity to benefit, achieving the best outcomes for all patients requiring the service.

Why is this important for community and patients?

Cardiac disease is a major cause of death, illness and disability in our population and contributes to the ethnic differences in life expectancy. Evidence shows variation in the ability to gain timely access to key evidence-based cardiology investigations and cardiology management across the primary/secondary care continuum in the Northern Region. This variation impacts on the outcomes for people.

We need to continue to ensure there is equal access and equal outcomes for all members of our community, specifically Māori and Pacific people. We need to ensure that we are consistently providing services to all members of our community within clinically acceptable waiting times.

We need to do further work to ensure that services are being provided to individuals who stand to gain the most benefit and to ensure that there is regional consistency in access to services.

The Northern Region's Cardiac Clinical Network has identified the following issues with Cardiovascular management in the Northern Region:

- There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum
- High deprivation (NZ Dep) and geographically and/or culturally isolated population groups do not meet accepted intervention rates and have poorer health outcomes
- The reporting infrastructure to measure activity and support improvement initiatives is incomplete across the region for both primary and secondary care

Progress to date

Last year Auckland DHB worked with the Northern Region's Cardiac Clinical Network to meet the following agreed objectives for the 2012-13 Regional Service Plan.
The Northern region's Cardiac Clinical Network was strengthened by:

- Appointing a Clinical Leader for a two year term to succeed the current Clinical Leader
- Integrating primary care in workstream initiatives
- Establishing a closer working relationship with the Diabetes Clinical Network and sharing initiatives that combine CVD risk Management and Quality Improvement with diabetes clinical indicators
- Current achievement for outpatient coronary angiogram (for quarter 1, 2012-13): 100% of people were seen in less than 3 months compared with 95% for the same quarter in 2011-12
- The ratio of median wait times by all ethnicities compared to Other is 1.09

In development:

- Ongoing maintenance of Cardiac Surgery targets have been achieved. We ensure appropriate capacity is available to meet targets. Priority has been placed on operating the Cardiothoracic Surgical Unit (Auckland City Hospital) at higher capacity with the appointment of an additional cardiac surgeon and contracting to outsource cardiac procedures work programmes
- Documentation further developed to support CVD Risk Management and discussed within the secondary and primary care sector
- Clinical Guidelines for treating out-of-hours STEMI are completed. Guidelines have been circulated within each DHB in order to maximise care and minimise variation
- An agreed Regional Electrophysiology Services (EP) model of care has been developed and regional reporting for EP services is now underway
- Sector feedback sought and received re the Northern Region Primary Care Medication Adherence in CVD report

How are we going to do it? (Key planning approach)

We want to achieve adequate, timely and equitable levels of access to key cardiac assessment and management across the patient journey through primary and secondary care. We will work with the Cardiac services providers in our district and the region to establish a clear understanding of what range and level of services will be funded and provided for the Auckland population. Models of care will be developed and promoted that better meet the demand and regionally agreed standards of care by:

- Reducing waiting times for First Specialist Appointments and follow up visits
- Providing better support for discharged patients
- Improving patient outcomes including equity of access

Specific actions to deliver improved performance

- Ensure the appropriate capacity is available to meet equity of access, cardiac surgery demand and managing CVD across the continuum of care
- Ensure that the local cardiac surgical registry data is able to be shared with the national cardiac registry in development
- Improve CVD assessment and management rates across the sector by continuing to support the implementation of key CVD Risk recommendations through the Cardiac Network care across the continuum
- Ensure consistency of clinical prioritisation for cardiac surgery patients by achieving consistency of data used in the national cardiac CPAC tool. Treating patients according to assigned priority and time waiting. Cardiac surgery patients are operated on within nationally agreed urgency timeframes
- In order to support plans to identify and address gaps in equity, we will collect all indicator data by ethnicity
- Implement information system (Acute Predict) to facilitate measurement of acute coronary syndrome timeframes and outcomes
- Establish a local lead for supporting the implementation of the acute coronary syndrome pathway and information tool
- Establish quality improvement group to support the local and regional initiatives and KPI targets
- Support and participate in regional cardiac data reporting
    - remaining Regional Key Performance Indicators developed
    - complete implementation of Acute Predict platform to support ongoing reporting and service improvement in Acute Coronary Syndrome

How will we know we've achieved it? Measured by:

- 90% of patients appropriately referred, receive echocardiogram within 150 days of referral
- 90% of eligible patients have had their cardiovascular disease risk assessed in the last 5 years by July 2014
- 80% of all outpatients triaged to chest pain clinics seen within 6 weeks for cardiology assessment and stress test
- 85% of out-patient coronary angiogram waiting time to <3 months (90 days)

- 70% of patients presenting with an acute coronary syndrome who are referred for angiography receive it within 3 days of admission (day of admission being day 0)
- 80% of patients presenting with ST elevation myocardial infarction and referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes
- Maintain the nationally agreed cardiac surgical delivery and waiting list management targets
- 95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection, progress reported quarterly
- Acute Coronary Syndrome information system will be operational by 1 July 2013, progress reported quarterly
- Local lead and quality improvement group in place and operational by quarter 2.

3.3.4 Primary Care

What are we trying to do?

Develop a more cohesive, accessible, efficient, effective, safe, and sustainable health system for our community through:

- Supporting primary care to develop a context for Self-Directed Care thereby empowering people to make informed decisions about their healthcare
- Increased integration of community, primary care, and secondary care health services through locality development
- Build capability and capacity by increasing the scope of primary care
- Supporting, where appropriate, infrastructure development within primary care
- Drive performance through quality improvement and transparent reporting

Why is this important for community and patients?

Care will be tailored to the needs of individuals and healthcare services will be provided based on the needs of the local population through localities planning. The localities approach helps to address the social determinants of health and improves health outcomes as well as reducing inequality in health outcomes across population groups.

Service integration is also important for improving patient outcomes and experience. A more integrated health system where clinicians work together across and within the health system will ensure that appropriate healthcare services are delivered in the right place (closer to home where appropriate) at the right time. Better use of resources will also address the current and projected demands on our health care system caused by a growing and aging population, increasing expectations around quality of clinical outcomes and our current economic challenges.

We need to improve how we plan and monitor services together with our communities, and how individuals access and journey through our services, thereby creating a more efficient, effective and sustainable health system.

Progress to date

- We have made real progress with the opening of integrated family health centres - shifting services to Whānau House in Henderson and opening the New Lynn integrated family health centre (WDHB)
- We have spent a significant amount of time developing relationships at a locality, DHB and regional level
- We are reorientating governance structures so our DHBs can implement strategies regarding patient-focused health care, Waitemata DHB's purpose statement and Auckland DHB's self-directed care strategy
- A metro Auckland primary care clinical governance group (PCCAG) is operational and drives performance and quality across the whole system
- Auckland and Waitemata DHBs have recently completed a request for proposal process to identify the best way of delivering integrated National Immunisation Register/Outreach Immunisation service to the two districts. An NGO provider was the successful and will work with PHOs and other primary care partners to improve the performance of these services
- The West Auckland locality network is established and operational, supporting 3 integrated work streams to review the models of care for urgent care, diabetes and child health. The two integrated Family Healthcare centres are in the West
- The North Auckland locality clinical network and health needs assessment has been initiated with a Clinical Director in place to lead this work
- Significant community engagement, health needs assessment and service mapping has been completed for the localities in Auckland DHB with a Clinical Director in place to lead future work

How are we going to do it? (Key planning approach)

- Engage key provider stakeholders across the whole of system and work with our communities to ensure consistency of service where this is needed
- Encourage all primary care providers to participate in GAIHN and appropriate clinical governance structures, and to incorporate other activities, e.g. move regional after-hours project into the GAIHN work programme
- Continue to develop relationships at a locality, DHB and regional level to support service changes required
- Conclude the process of reorientating the governance structures that enable Auckland and Waitemata DHBs to implement their key strategies: patient-focused health care, Waitemata DHB's purpose statement, and Auckland DHB's self-directed care strategy
- The West Auckland locality network will support the three integrated workstreams to review models of care for: urgent care, diabetes, and child health
- Use a locality development approach to:
  - work with communities and providers at a locality level
  - enhance patient and community engagement
  - identify local priorities

  - drive local delivery of Northern Region Health Plan, GAIHN initiatives and government objectives to increase health outcomes
  - support change management initiatives
- Continue integration across whole of system via an agreed programme of work
- Increase patient enrolment with practices via a dedicated communications plan
- Improve data collection and reporting via a specific collaborative project under the shared programme of work

Specific actions to deliver improved performance

Localities

- Structures implemented to support locality development including:
  - a Localities Governance Group including managers and clinician representatives from DHB, PHOs, other providers, Iwi, local boards and community by 30 September 2013
  - a jointly agreed programme of work around self-directed care and locality-based services, developed by 31 December 2013 and updated in quarter 3 and 4
  - engage with clinical and community networks to formalise localities in Auckland DHB around local boards and in the North Auckland locality, by 31 December 2013
  - engage with key stakeholders to determine the location for physical or virtual hubs (Integrated Family Health Centres or Whānau Ora Centres) within Auckland DHB localities and in the North locality, by 30 June 2014 and West Auckland locality by 30 September 2013
- West Auckland, North Auckland and Auckland DHB locality plans initiated by December 2013
- Jointly agree with key stakeholders, a management plan for high risk individuals as identified by predictive risk modelling in primary care (identify patient group quarter 1) develop management plan (quarter 3), pilot (quarter 4)
- Local Health Partnerships established in each local board area by 31 March 2014 (ADHB)
- Central HealthLinks established with representation from each local board area by 30 June 2014 (ADHB)
- Co-design (community and funders) a priority service area in an Auckland local board community as identified by key stakeholders, by 30 June 2014 (ADHB)
- Support implementation of the Community Pharmacy Services Agreement through:
  - engaging primary care prescribers and secondary care services
  - supporting community pharmacy to embrace the localities based approach and integrated service development (quarter 1 develop communication materials to help pharmacists engage locally, quarter 2 roll out to pharmacies)
  - the continued engagement of prescribers and other health care professionals with pharmacy, through locality-based initiatives e.g. intersector peer support networks (ongoing)

- Develop a regionally consistent stepped care model for primary mental health through localities. Collaborative project plan to be created by quarter 1
- Diabetes Quality Improvement Team to review and support practices with high enrolment of Māori and Pacific patients in the West to provide better diabetes care
- Plan and begin the implementation of an integrated urgent care system across Auckland and Waitemata by quarter 4
- Implement at least two initiatives as prioritised by the Child Health workstream in West Auckland

Integration and services closer to home

- Maintain direct access for general practitioners to full suite of diagnostic imaging including X-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MR, with a focus on reducing waiting times for ultrasounds (establish baseline quarter 1, 10% reduction in waiting times by 30 June 2014) (WDHB)
- GPs have direct access to MRI to exclude acoustic neuroma, Renal Doppler Ultrasound and Renal Magnetic Resonance Angiography (MRA) after discussion with consultant (ADHB)
- Electronic referral templates developed by a working group comprised of primary and secondary clinicians, implemented by quarter 2 to enhance general practitioner access to radiology service
- Direct referrals by general practitioners to elective booking lists or to a GP with special interest will be in place for skin lesions, mirena insertions, ring pessaries, pipelle biopsies, cervical polyps, tubal ligation and pre-termination assessment (ADHB) (Confirm current practice and establish baseline quarter 1. Identify any enablers or process changes required quarter 2. Implement changes required quarter 3. Direct referrals to identified booking lists in a minimum of two services fully in place by end of quarter 4)
- Direct referrals by general practitioners to elective booking lists will be in place for skin lesions, vasectomy, mirena insertions and ring pessaries (WDHB) (Confirm current practice and establish baseline quarter 1. Identify any enablers or process changes required quarter 2. Implement changes required quarter 3. Direct referrals to identified booking lists in place by end quarter 4)
- Primary Care access and streamline referral process pathways to the Elective Surgery Centre (orthopaedics) in place by quarter 2 (WDHB)
- Direct access for general practitioners to specialist nurse and /or doctor advice in paediatrics, renal, diabetes, gerontology, dementia, palliative care and cardiology (WDHB) (Confirm current practice and establish baseline quarter 1. Identify any enablers or process changes required (eg processes to ensure any advice provided is captured in clinical notes) quarter 2. Implement changes required quarter 3. Direct access in place for identified specialties by end quarter 4)
- Direct access for general practitioners to specialist nurse and/or doctor advice in paediatrics, renal, cardiology, general medicine and general surgery (ADHB). (Confirm current practice and establish baseline quarter 1. Identify any enablers or process changes required (eg processes to ensure any advice provided is captured in clinical notes) quarter 2. Implement changes required quarter 3. Direct access in

place for identified specialties in a minimum of three services fully in place by end quarter 4)
- Work in partnership with primary care to develop a consistent framework of management for direct access to services by 30 June 2014
- Work with PHOs and regional Primary Options for Acute Care members to continue to support the services across Waitemata (6,150) and Auckland (5,700)
- The Waitemata DHB chronic pain management service will work more closely with general practices, improving their availability via telephone and email contact and by having regular interactive workshops. These workshops will help specialists share knowledge with primary care practitioners. This will improve the community-based management of patients with chronic pain. The service will operate with a concept of 'partnership in pain management' between the patient, general practitioner and hospital specialist service
- Develop an integrated system approach between primary and secondary care services for the delivery of sexual health services for the Waitemata DHB population

Primary Health Organisations (PHOs)
- Work with PHOs to jointly achieve PHO Performance Programme (PPP) targets and health targets each quarter
- Continue current projects to improve PHO enrolment and data accuracy especially among high need individuals

How will we know we've achieved it? Measured by
- KPI framework for localities implemented
- Direct access to diagnostic volumes are increased and waiting times are reduced
- Governance structures established
- Memorandum of Understanding and data-sharing agreement signed by all parties
- Locality based network mechanisms developed and implemented
- All PHO Performance Programme targets achieved
- All health targets achieved
- Management plan for high risk individuals piloted and reviewed for future roll out
- Roll out of communication information to pharmacies
- Creation of peer networks within the locality/clusters (GP, Nurses, Allied Health Practitioners and pharmacists)
- Minimum 10 West Auckland practices reviewed by the Diabetes Quality Improvement Team
- Establish baseline data to identify percentage of patients treated for chronic pain management in primary care settings versus those treated in secondary care by 30 June 2014
- Initial integrated sexual health services system model developed by July 2014.

3.3.5 Mental Health (Service Development Plan)

What are we trying to do?

- Provide early and effective best practice interventions
- Increase access to integrated Mental Health and Alcohol and Drug (AOD) responses, across the continuum (primary, secondary and tertiary care, and NGO services)
- Enhance 'whole of sector' responsiveness across age related pathways for Mental Health and Alcohol and other Drug services using best practice models
- Reduce wait times for DHB and NGO services
- Ensure services are responsive and equitable for diverse cultures
- Contribute to a reduction in suicides
- Use resources more effectively

Why is this important for community and patients?

- There's no health without mental health
- Families/whānau and individuals are better able to build resilience if information, assessment, or treatment is available when mental health or addiction problems emerge
- Multi-agency responsiveness ensures different needs are met for the most complex problems
- Addressing inequalities and increasing access to services produces better mental health and addiction outcomes for everyone
- Meets expectations of Blueprint 2 and the Service Development Plan
- Delivering improved mental health services addresses government strategies (Drivers of Crime, Suicide Action Plan, Welfare Reforms)

Progress to date

Child and Youth:

- Child and youth multi-agency planning project established to lead and implement cross-sector change process
- Elements of the Choice and Partnership Approach (CAPA) implemented
- Analysis of wait times and access to Child and Adolescent Mental Health Service
- Access rates better than the target
- Stocktake and gap analysis begun

Adult and Primary Care:

- Primary care liaison nurse roles established
- Project started to explore secondary and primary integration
- Access rates better than the target
- Contract changes to facilitate support in primary care for people with severe mental health problems especially long term
- Primary care mental health review project underway to ensure service effectiveness and integration

Older People:

- Project started to analyse multi-agency responsiveness, map services, identify gaps, improve wait times, and increase access
- Dementia pathway project starting

How are we going to do it? (Key planning approach)

Child and Youth:

- Reconfigure Child and Adolescent Mental Health Services through systems analysis and lean thinking to reduce wait times and improve access
- Contribute to the Prime Minister's Youth Mental Health project, especially providing consultation to enhanced school based services, school counsellors, and school nurses
- Explore the role for primary care liaison in facilitating youth mental health care in GP practices
- Improve access rates to services by reconfiguring clinical services

Adult and Primary Care:

- Primary care mental health project to explore how to provide better mental health services through stepped care approach that works closer with specialist services and offers psychosocial interventions for those most in need, including housing and employment support, and service navigation
- Implement the restraint and seclusion minimisation plan in inpatient service

Older People:

- Project begun that will provide future planning options for multi-agency pathways and options for improving connections between mental health and personal health for older people for better outcomes
- Project will also explore and define options for improving community rehabilitation services to support people to remain at home

System Wide:

- Stocktake and gap analysis: for child and youth, and older people, as part of current project work
- Explore the potential for extending delivery into online environments including the use of social media and 'e-space' options - especially beneficial for Māori who have high usage rates for social media

Specific actions to deliver improved performance

Child and Youth:

- Reshape Child and Adolescent Mental Health Service referral pathway to reduce wait times and improve access by 1st October
- Reconfigure clinical services to increase access rates for children and youth
- Explore and define possible primary care liaison role for youth by 1st August 2013 and explore options to measure; focus on options to facilitate access for Māori

- Map and plan implementation of a multi-agency pathway that provides better value for money and removes duplication
- Adopt a stepped care approach matched to specialist level of intervention delivered where young people are based; designed to improve access for rangatahi who have reduced access to GP based services, and to improve the use of available resources
- Contributions from Child and Adolescent Mental Health (CAMHS) and Alcohol and Other Drug (AOD) services towards the Prime Minister's youth mental health programme including the potential for a youth focussed primary care liaison role

Adult and Primary Care:

- Increase the rates of access to mental health services by using the workstreams set up for service development
- Commission primary mental health service that meets key requirements for psychosocial model and stepped care: to include improved integration with specialist services and potential role of NGOs to achieve this objective, particularly through the planned and staged implementation of the GAIHN depression pathway
- Analysis and evaluation of employment support services across specialist and primary care services, including those commissioned by the Ministry of Social Development, collaboratively with Waitemata DHB. This project will align with welfare reforms that seek to support people's return to work and away from income support. Services for Māori are already in place as part of the Kaupapa Māori service provision using evidence-based supported employment model. The same model is used by Auckland DHB with the Community and Inpatient focussed employment support services already in place, and we will look to connect these to local WINZ offices
- Start project to explore the mental health needs of homeless people (health inequalities)
- Reduce adult suicides through staff training, and health promotion, e.g. Big White Wall service – as part of our contribution to the national Suicide Action Plan.
- Explore the potential for regional Alcohol and Drug (AOD) providers (NGOs and DHB services) to connect with local WINZ offices for referral pathways once likely numbers for referral are understood and service capacity managed

Older People:

- Older People's project will define options for integrating personal and mental health older people's services. There will be a focus on Māori who experience age related problems at younger age
- Complete older people's project to understand options and potential requirement for reallocating funding to develop wrap around services for acute inpatient care
- Develop an implementation plan for a dementia care pathway
- Explore e-therapy and e-support options e.g. Big White Wall for older consumers especially 'younger' old (older people's project)

System:

- Explore means to measure access in primary care for a range of mental health problems, especially high prevalence ones
- Ensure links to Whānau Ora are made through specific project work

- Undertake a project to ensure existing outcome measures are widely used including those from KPI project, across all ages and service environments

How will we know we've achieved it? Measured by

- Stocktake and gap analysis completed for different age related pathways
- Wait time and access targets met, with a special focus on the 0-19 age group
- Suicide prevention and postvention plan fully implemented
- Progress towards identification and use of primary care access rates across age range especially for tackling health inequalities for Māori , Pacific, and vulnerable groups, e.g. Lesbian, Gay, Bisexual, Trans, Takatapuhi and Intersex communities (LGBTTI), Muslims, and refugees
- Establish baselines with Waitemata DHB for employment status using 'Knowing the People Planning' or equivalent, and monitor changes from existing employment service and employment project improvements.

3.3.6 Whānau Ora

What are we trying to do?

Achieve whānau ora by supporting whānau to achieve their maximum health and wellbeing. We will do so by providing the necessary information and support for them to choose the services they want, when they require them. This will include supporting the Te Puni Kōkiri Whānau Ora Collectives to become mature providers through strategic development, capacity and capability development, and continued support for the implementation of their Programmes of Action.

This will also require a shift in the way in which we provide and monitor the system to ensure an increased focus on achieving outcomes and tangible health gain for Māori and Pacific families. Provider Collective members in the Auckland and Waitemata DHB regions are: Orakei Māori Trust Board, Te Whānau O Waipareira (as a member of the National Urban Māori Authority), the Pacific Island Safety and Prevention Project, and Alliance Health+.

Providers working to achieve whānau ora in both Auckland and Waitemata districts have included Māori, Pacific and mainstream health providers. In order to achieve the Ministry of Health's priority to support the whānau ora collectives achieve their own priorities, an agreed approach is required that encompasses all of this activity. This agreed approach will be broad enough to be applied across the diverse providers and approaches, explicitly state the support the whānau ora collectives will receive, and provide leadership for the sector to achieve whānau ora.

Why is this important for community and patients?

Improved outcomes for whānau are dependent on:

- Mature, resilient providers with maximised capacity and capability

- A health system that works in a seamless and integrated way with other parts of the social sector
- Adoption of a 'contracting for outcomes' model
- Whānau, community input and identified needs in planning and funding decisions also influence the way we provide services in our hospitals. This requires changes at the highest level of the organisation to adopt a whānau focus aligned to Whānau Ora

Progress to date

- The DHBs are represented on the Whānau Ora Regional Leadership Group for the Auckland region
- Whānau ora assessment tool implemented at Auckland City Hospital

How are we going to do it? (Key planning approach)

- Complete a Whānau Ora approach that provides the direction for Whānau Ora in our region (Auckland DHB and Waitemata DHB). We will do this in partnership with our Memorandum of Understanding partners, the Whānau Ora Collectives and Māori health providers in our region
- Work with Whānau Ora Collectives to achieve 2013-14 priorities and monitor outcomes
- Use formative and process evaluation methods to inform co-location activity and increase integration between the DHB and community based providers
- Support the national roll-out of HealthStat for Whānau Ora providers and explore options for analysing primary and secondary data to better understand patient pathways across primary and secondary care
- Explore the link between multiple readmissions of older Māori and whānau ora assessment and referral from secondary care to primary care whānau ora providers

Specific actions to deliver improved performance

- Complete an agreed Whānau Ora approach by December 2013 with implementation work commencing by January 2014
- Work with the Whānau Ora Collectives to integrate their health contracts and align these to the Whānau Ora Outcomes Framework by 1 June 2014
- Establish a forum for Whānau Ora Collectives and DHB representatives to monitor shared activity and align strategic priorities by 1 August 2013
- Formative/process evaluation in place and findings inform future service integration work programmes by December 2013
- Support the roll out of HealthStat. Work with Whānau Ora providers to review their Practice Management systems and programmes for enhancing preventative care at the practice level, by February 2014

How will we know we've achieved it? Measured by

- A district health board and Memorandum of Understanding partner whānau ora approach approved by both Auckland and Waitemata DHB boards by Dec 2013
- Formative evaluation completed and recommendations prepared for implementation by the end of quarter 2
- Monthly meetings with Whānau Ora collectives held
- Two integrated contracts in place by end of quarter 4.

3.4 Targeted Preventive Strategies

3.4.1 More Heart and Diabetes Checks and Diabetes Care Improvement Package

What are we trying to do?

Reduce the health problems and premature deaths caused by cardiovascular disease and diabetes through:

- early identification of those at-risk to ensure they receive appropriate advice and care
- providing the opportunity for people to self-direct their care and seek services before they have a well established disease
- Deliver evidence-based support designed to help people manage long term conditions to the best of their ability
- Address inequalities for Māori and Pacific

Why is this important for community and patients?

Over 800 Auckland DHB residents die of ischemic heart disease, stroke and diabetes every year. Cardiovascular disease when present with diabetes compounds the clinical risk for people and increases their likelihood of having more health problems. This leads to complex medical, pharmaceutical and social care that the individual will need to navigate.

Older populations and Māori and Pacific people are particularly at risk. Reducing the risk of acute admission to hospital and improving heart and diabetes check rates, along with the provision of information to help people reduce their risks, will improve health outcomes for our population.

A patient and whānau centred approach is needed to support and improve the health of people with Long Term Conditions, and vulnerable populations. This approach reduces the impact on the individual, their family, and the health system. For these reasons Auckland DHB, the Northern Region and the Ministry of Health continue to focus on this area. In 2013-14 'more heart and diabetes checks' continues to be one of the six national health targets.

Progress to date

- We have increased the number of heart and diabetes checks to achieve 54% coverage of the population
- 69% of the target population have completed their diabetes annual review as at March 2013
- Of those completing their diabetes annual review, as at March 2013, 62% have good diabetes management
- Diabetes care improvement packages have been implemented from the PHOs

- The PHOs have provided educational cell group sessions, nurse resource, and utilised support from the Long Term Condition Co-ordinators to support their practices to develop quality improvement practice plans addressing diabetes service delivery

How are we going to do it? (Key planning approach)

- Work with the Northern Region Diabetes and Cardiac Networks to support their activity to develop regionally consistent indicators and services
- Engage with the Auckland DHB locality to ensure services for chronic conditions provides evidence-based care and are linked to existing strategies
- Continue to work with the Primary Care based Long Term Conditions Quality Improvement Team to improve long term conditions (particularly CVD and diabetes) services within general practice. Primary and secondary care will work together to provide integrated quality care
- Identify key secondary care services to support CVD assessment and management i.e. Diabetes service
- Continue to develop and refine the diabetes care improvement package indicators with primary care to improve the outcomes for people with diabetes in Auckland DHB
- To maximise the resources and outcomes by working with our Māori and Pacific providers and linking with existing services such as Te Hononga Whānau Ora Long Term Conditions Co-ordinators
- Timely submission of quarterly reports from the PHOs for the Diabetes Care Improvement Plan
- Quarterly and monthly contract review meetings with PHOs to manage programme implementation and performance

Specific actions to deliver improved performance

- DHB funding for cardiovascular risk assessment and management services will be utilised by the PHOs to ensure general practices risk assess 90% of their eligible populations
- Ensure monitoring and reporting by ethnicity so that identified inequalities can be linked to action plans for improvement
- PHOs will provide the DHB with their annual plan to achieve the more heart and diabetes checks by end of quarter one 2013-14
- The DHB will receive weekly and quarterly progress reports from the PHOs on the number and percent of their eligible population that have had a five year heart and diabetes check to ensure they are on track to meet the 90% target by 30 June 2014
- DHB funding for cardiovascular risk assessment and management services will be used within primary care to support achievement the 90% target. Total resources allocated are $700,312.00. This will be used for performance-based funding contracts with all PHOs, support for the use of Electronic Decision Support tool (EDS) for PHOs and funding for 3 FTE Long Term Conditions coordinators to work in primary care to support practices with both CVD and Diabetes patients and to provide quality support

- The DHB and PHOs will meet at least monthly to discuss progress towards achieving the target and to understand PHO plans should performance fall below expectation
- Link our work to the Northern Region Cardiac Network and PHOs, using the Northern Region Cardiovascular Risk Register to improve more heart and diabetes check rates across the district by analysing practice specific performance
- Each PHO will demonstrate quarterly that they have maintained the 75% target for good diabetes management (HbA1c of ≤ 64mmol/mol)
- Promote the primary care diabetes nurses workforce development through promoting the new online programme by the NZ Society for the Study of Diabetes
- Continue to develop and expand our supported self-management programme for people with diabetes and other Long Term Conditions including the addition of diabetes self management support delivered via the Healthy Village Action Zone programme
- Primary care workforce will be able to continue to access New Zealand Diabetes and New Zealand Society for the Study of Diabetes online education package
- PHOs will provide quarterly performance reports on the delivery of the Diabetes Care Improvement Package which includes diabetes annual reviews and diabetes management indicators
- Review and improve the current parameters of the Diabetes HBA1c management indicator and incentive payment model of the Diabetes Care Improvement Package, by the end of quarter 3
- Conduct a review of the Diabetes Care Improvement Package contract specifications and processes to improve, strengthen and develop a regionally consistent approach, by end of quarter 3

How will we know we've achieved it? Measured by

- 90% of the eligible population will receive their heart and diabetes check by June 2014
- 75% of the eligible population will achieve good diabetes management
- 90% of the eligible population will have had a Diabetes annual review
- Percentage of people with diabetes and a CVD risk assessment greater than or equal to 15% on antihypertensive medications – maintain or improve
- The number of people with baseline HBA1c greater than 64mmol/mol who have had an HBA1c reduction of 1mmol/mol or more, by ethnicity
- Improve or maintain appropriate management of microalbuminuria in patients with diabetes
- An improved HBA1c diabetes management indicator developed and used, taking into consideration learnings from the Waitemata DHB cohort study
- Adoption and implementation of the suggested improvements to the Diabetes care Improvement Plan, resulting in improved programme implementation, management, primary care relationships and achieved outcomes.

3.4.2 Better Help for Smokers to Quit

What are we trying to do?

Reduce the harm caused to our patients and community from tobacco use and environmental tobacco smoke through effective prevention and cessation activities, particularly focused on Māori, Pacific, pregnant women and youth.

Achieving the health target of 95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals, and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking.

Why is this important for community and patients?

Smoking is the single most important cause of premature and preventable deaths in New Zealand, yet approximately 13% of people living in our district smoke. Māori and Pacific people are more likely to smoke (38.4% and 23.1% respectively) and these groups, along with pregnant women, are more likely to experience negative health impacts.

Progress to date

- 95% of our patients who are seen in public hospitals receive brief advice to quit smoking as at December 2012
- 37% of patients seen in primary care are currently offered brief advice to quit
- Cessation services are in place with referral processes for patients who wish to have support to quit, including Māori and Pacific providers. In the Auckland DHB district there are 4 face-to-face services available in the community to help patients to stop smoking: Auckland DHB Smokefree Pregnancy Service, Ngati Whatua Aukati Kai Paipa (AKP) service, Pacific Quit, and South Seas Healthcare
- Auckland DHB policy ensures a healthy, smokefree environment for all employees, patients and visitors, and provides support for staff to stop smoking
- To date, 85.6% of Women's Health patients who smoke were given brief advice to stop smoking. Of 170 patients referred to Auckland DHB Smokefree Pregnancy Services, 90 were enrolled into the quit smoking programme
- Auckland DHB funds 2 designated Smokefree Co-ordinators within the PHOs to assist and support the implementation of the ABC approach to smoking cessation in primary care and to lead the Smokefree PHO deliverables for the Auckland DHB catchment area

How are we going to do it? (Key planning approach)

- Auckland and Waitemata DHBs will work collaboratively to meet the health target and to work with communities and primary care to reduce smoking-related harm
- All smokefree activity and services will focus on Māori , Pacific and pregnant women as priority populations
- Working collaboratively with ProCare, and the National Hauora Coalition (as the lead PHO for smokefree for Alliance Health+ and Auckland PHO) on reducing the smoking

rate. By routinely asking all patients if they smoke, and offering brief advice and cessation support if they do, to achieve the tobacco health target for our region

- Auckland DHB will have a community liaison smokefree facilitator in place to work alongside the 2 PHO Smokefree facilitators from the beginning of the 2013-14 plan

Specific actions to deliver improved performance

Primary health

- PHOs in conjunction with the DHB will produce comprehensive plans on how they will meet the Health Target in 2013-14, by August 2013
- PHOs will ensure that at least 85% of GPs and Nurses are trained in the Ask, Brief Advice, and Cessation (ABC) support approach. A record of training status is maintained and reported on quarterly
- PHOs will complete an audit of smoking interventions data accuracy and up-date information where required in 75% of general practices
- A register is maintained of all current PHO staff and general practice staff who are Quit Card providers, by end of quarter 2
- Survey PHO and general practice staff who are Quit Card providers to understand the challenges with providing Quit Cards to people who smoke, any additional training required, and suggested improvements to giving brief advice and cessation support. Completed by end of quarter 3
- Re-establish the Auckland Regional Cessation Providers Network and meet bi-monthly (supplying both clinical and management information)
- Auckland and Waitemata DHBs will, where appropriate, work together to facilitate smokefree training for community-based health professionals e.g. dentists, lead maternity carers
- The DHB will require all contracted NGO providers to have a comprehensive Smokefree Policy, by June 2014

Adult Health

- All in-patient wards will have a trained and resourced smokefree lead to facilitate training in their area, to maintain information stocks, and to carry out an audit of patient smokefree status once a month, by quarter 4
- Review and refurbish the current Assessment and Referral form, by end of quarter 1 and roll this out to all areas (Adult Health, Paediatrics, Women's Health, and Mental Health), by end of quarter 2
- Continue a monthly rotation of ward audits already in place, as well as weekly feedback to charge nurses on the status of their ward in achieving the ABC target, and provide feedback when a person is missed
- Ensure Māori and Pacific Smokefree targets are met at each quarter

Paediatric Health

- Auckland DHB will have a smoking assessment and referral mechanism in place both for the child and/or whānau who smoke, by quarter 2

Maternal Health

- Each of 3 Smokefree Pregnancy Facilitators will provide at least 120 pregnant women smokers help to stop smoking
- Auckland DHB Smokefree Services will facilitate departments to reach and sustain a 95% target of all current smokers receiving brief advice to quit smoking
- Auckland DHB Smokefree Pregnancy Service will provide a quarterly report on meeting its target
- Monthly contact with all midwives, including those who work for Auckland DHB or work independently, to facilitate approximately 42 referrals per month
- Work with other pregnancy cessation providers in the Auckland DHB area to develop a plan to improve cessation advice services for pregnant women and met the target: 'progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy, in general practice or booking with a Lead Maternity Carer, are offered advice and support to quit'. (Terms of Reference for the group by end of quarter 1; agree actions to improve the service by end quarter 2; implementation plan developed by end quarter 3; and complete implementation of the plan by end of quarter 4)

Mental Health

- Mental Health inpatients will have access to the Quit Mist oral spray to manage cravings to smoke in association with nicotine patches, lozenges, and gum, by end quarter 2
- All contracted Mental Health Community accommodation will have stated Smokefree policies, by end of quarter 3

How will we know we've achieved it? Measured by

- Consistent achievement of the ABC target so that 95% of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking
- 90% of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking in all 4 PHOs by end of quarter 4
- 90% of pregnant women who are smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit (across all ethnic groups)
- Contracted NGOs will have comprehensive Smokefree policies in place by June 2014
- The Auckland Regional Cessation Providers Network meetings are occurring regularly by December 2013.

3.5 Acute and Unplanned Care

3.5.1 Shorter Stays in Emergency Departments

What are we trying to do?

We want to deliver high quality emergency care to our community by exceeding the health target (95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours) and ensuring only patients who need emergency care are seen there.

We want to increase the acute flow performance and reduce demand for acute hospital services by supporting patients at home including aged residential care. We also want to provide alternatives to transporting acute patients to hospital for St John.

Why is this important for community and patients?

Our patients expect and deserve better, sooner and more convenient healthcare. They want to receive care and treatment in the right place by the right people, preferably in a community setting rather than in hospital, and do not want to be readmitted to hospital unnecessarily.

Less time spent waiting and receiving treatment in the Emergency Department not only gives patients a more dignified and timely experience when they are acutely ill, but also gives rise to better outcomes and enables us to use our resources more effectively and efficiently.

The national health target is a measure of the efficiency of flow of acute patients through the hospital and into the community. It provides a whole of system's view of the organisation including primary and secondary service delivery.

Progress to date

Overall we have performed well with our goal of achieving acute flow for our patients in all bar the winter peak periods. We average 95% outside of the winter months but drop to 92% through winter.

Auckland DHB implementation plans that shorten stays in our emergency departments are supported by our senior management team and clinical staff. The CEO releases weekly progress reports (by speciality area) to the organisation. There is high visibility of performance in this area.

How are we going to do it? (Key planning approach)

- Remove duplication of documentation between the Emergency Department and the inpatient teams
- Improve the coordination between Adult Emergency Department and Inpatient teams to reduce wait time for patients

- Continue the development of the bed forecasting tools and routines to minimise bed block issues
- Develop our district nursing model to provide options for urgent care
- Work with St John on alternatives to transporting patients including acute referrals for district nursing
- Implement community transition activities to support Length of Stay reductions and reduce avoidable admissions in Emergency Department
- Leverage Primary Option for Acute Care investments for IV in Aged Related Residential Care
- Improve the response to falls and pressure injuries in Aged Related Residential Care facilities to reduce admissions

Specific actions to deliver improved performance

- Duplicated documentation eliminated in the Adult Emergency Department by quarter 1
- Reduce referral to sign-on time for inpatient specialty teams with 95% sign on within 1 hour
- Bed forecasting to support bed management and reduce bed block delays measured by time from bed request to leave Emergency Department <1 hour
- The acute district nursing model to be established in 2013
- Provide St John with referral pathways for urgent care as an alternative to transport. Minimum: 1 new pathway developed
- Community transition team established along with a target for the number of patients who avoided admission
- Reduce acute presentations to the Adult Emergency Department through supporting GAIHN's predicative risk analysis

How will we know we've achieved it? Measured by

- 95% of patients will be admitted, discharged, or transferred from Emergency Department within six hours
- CT and MRI – 85% of accepted referrals for CT, and 75% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).

3.5.2 Long Term Conditions

What are we trying to do?

Ensure that those with health problems caused by chronic diseases are better managed through services located closer to their homes with the opportunity for people to self-direct and manage their own care whenever possible.

A multifaceted, multidimensional approach is needed to reduce the impact of Long Term Conditions. By taking a comprehensive approach, we are trying to:

- Support better health outcomes for individuals who have had a stroke and people at risk of stroke
- Provide a focus on individuals and their whānau / families at the centre of new service delivery structures
- Reduce inequalities in health status
- Support improved coordination of services and increase multidisciplinary approach across service areas and across community, primary and secondary boundaries
- Support optimised planned care service use that reduces unplanned acute service utilisation
- Support the development of new and the enhancement of existing self-management and patient directed care opportunities

Why is this important for community and patients?

For those living with long term conditions, particularly the frail elderly and vulnerable populations, services within the community increase their ability to receive timely care and treatment and remain living in their own homes. Early intervention with the provision of social support and clinical treatment has the potential to reduce avoidable admissions and disruption to activities of daily living. It is important that people understand how to access services and that they are involved in service development to ensure services are provided locally.

Long term conditions are placing an increasing burden on individuals, whānau, communities and the health sector. Conditions such as Diabetes, Heart Disease, Stroke, COPD and Asthma have increased, with Māori and Pacific Peoples being over represented in these figures.

The impact of Stroke and Transient Ischaemic Attack (TIA) can be catastrophic for the individual and family and is resource intensive for health services. Managing these events according to the NZ Stoke Management Guidelines (2012) and Assessment and Management of Transient Ischaemic Attack Guidelines (2008) is essential for improving and maximising health outcomes for people with a stroke, or who are at risk of stroke.

Progress to date

- We have been involved in the development of Northern Regional Network activities to develop clinical pathways and outcome indicators. The pathways and outcome indicators will be introduced across the DHB to increase consistency in care that people receive from their general practice
- We provide a self-management programme for people with diabetes. This service is available to a range of people and their families. Run by PHO staff, the service provides people with the skills to improve their health and reduce complications caused by chronic conditions
- Auckland DHB provides self-management support specifically targeted at Pacific communities via the Healthy Village Action Zone's programme using the evidence-based Stanford methodology. A specific Diabetes-focused programme module is also delivered. To aid delivery and improve patient engagement, the programme has

been translated (and is delivered) in Samoan and is currently being translated into Tongan

- The DHB currently supports self-directed care through information sharing. People within the community have two internet based tools that provide information about available services. These are Healthpoint and Healthnavigator
- Auckland DHB has had an identified stroke unit for 2 years and an established process for responding effectively to people suspected of having a TIA. There are clear pathways for managing suspected stoke and TIA patients who present at the Emergency Department or are referred from primary care
- Currently the stroke nurse specialists play a lead role in the process. They receive the Emergency Department, primary care and in-hospital referrals as well as identify the patients from admission lists, if not initially flagged to the service. They triage the patients, perform an initial clinical assessment, arrange investigations including brain and vascular imaging, and provide patient education
- The stroke unit is improving its data capture and reports that over 80% of stroke patients are either directly admitted to the stroke unit or are managed as outliers according to the pathway
- >80% of TIA patients referred to the "TIA Clinic" were seen within 48 hours of receipt of referral
- 11% of ischaemic stroke patients are receiving thrombolysis

How are we going to do it? (Key planning approach)

- The DHB will contract all providers to deliver services in a consistent manner to ensure equity of access for Māori and Pacific populations
- Continue to support self-management education through the provision of self-management education courses for people with long term conditions
- Support workforce development and training to increase the capacity to deliver self management courses e.g. supporting five places for the Stanford self-management master training course
- Support the translation of the Stanford programme into Tongan to maximise engagement and support health literacy
- Improve data collection for both Stroke and TIA data according to the regional pathways
- Support the training and upskilling of primary care using the Stroke and TIA - ABCD tool (quarter 3)
- In partnership with primary care, jointly agree with key stakeholders a management plan for high risk individuals as identified by predictive risk modelling (quarter 1- identify patient group). Develop management plan (quarter 3). Pilot (quarter 4)
- In partnership with primary care and with key stakeholders, streamline the referral and care pathway processes as linked to the regional programme milestones

Specific actions to deliver improved performance

- Work with the Auckland DHB Long Term Conditions Steering Group to develop a work plan, provide advice and act as conduits for information and activity exchange. This will maximise shared care across the service continuum
- Examine the service's delivery by ethnicity to ensure or/address (in) equity of care
- Ensure links to smoking cessation programmes are promoted and data capture is high within Hospital and Primary care services
- Support the Northern Regional Alliance (previously NDSA) to undertake a regional evaluation of Diabetes Self Management Education courses. The evaluation will ensure both the quality and consistency of delivery and will use the findings to contribute to improvements in service planning

How will we know we've achieved it? Measured by

- The Long Term Conditions Steering Group have an action plan by end of quarter 2
- The Northern Region Diabetes Network report against the indicators for improvement in diabetes care by quarter 1 (note: this work may be superseded by Ministry of Health indicator development)
- 6% of potentially eligible stroke patients are thrombolysed
- 80% of patients with stroke have a CT or MRI within 24 hours
- 100% of stroke patients are admitted to the stroke unit or managed according to the stroke pathway by the stroke service.

3.5.3 Health of Older People

What are we trying to do?

To improve the outcomes for older people we will:

- support and enable older people to participate to their fullest ability in decisions about their health and well-being
- work to streamline access for older people to all aspects of health services ensuring a 'right place, right time' experience
- grow integrated services to avoid hospital admissions after hospital discharge

Why is this important for community and patients?

We have an ageing population. Older people should receive coordinated and responsive health and disability services i.e. services that are accessible, flexible and timely. Integrating primary and community care across the health system enables patients to be treated closer to home with fewer acute and unplanned admissions into hospital. We need to ensure these services are structured and provided to make the best of use of health funding in order to meet increasing demands.

Progress to date

- Restorative Home Based Support Service model implemented

- 19 of 68 of Age Related Residential Care facilities participating in interRAI training
- Age Related Residential Care cluster model with host facilities established for collaborative management of falls and pressure injuries
- Project brief for Dementia Care Pathway developed and Governance Group established
- Specialist Health of Older People team proactively supporting Age Related Residential Care
- Flexible funding package for respite care established
- Health of Older People's Scorecard developed

How are we going to do it? (Key planning approach)

- Align with regional and national frameworks and guidelines
- We will participate in a home-based support services costing exercise through the Health of Older People steering group led by the lead DHB Chief Executive for Health of Older People
- Invest in smarter services for older people living at home, to reduce acute admission and readmission
- Achieve continuity of care through integration and clarity of access across the continuum e.g. Dementia Care Pathway
- Enhance and support skill development in the aged related residential care workforce
- Facilitate person-centred care and consideration of the needs of carers, whether family, whānau, friends or paid care workers ('relationship-centred care')
- Use flexible packages of funding to better meet the needs of older people e.g. older people wishing to remain at home with support and respite care
- Increase the level of acute care and rehabilitation in the community by increasing the scope of Home Based Support Services
- For older Māori , develop a strategy that will improve the way in which services we purchase and provide engage with Māori patients and their whānau. The focus will be on enhancing entry level assessments, integrating care coordination with primary care providers and relevant community organisations to prevent unplanned admissions. Also include discharge planning to prevent readmission to hospital. (Refer to the Māori Health Plan 2013-14 for more detail on this activity)

Specific actions to deliver improved performance

Quality home and community support services for older people:

- Work with home and community support services providers to implement the Home and Community Support Sector Standards NZS 8158:2012, by 1 September 2013
- Develop a system to analyse the interRai data set for home and community support services' clients using core quality measures (once produced by the Ministry of Health and Health Intelligence Ltd). Identify and manage any quality of service issues with our home and community support services providers

- Establish baseline data and benchmark our performance with other DHBs using core quality measures for home and community support services (once produced by the Ministry of Health and Health Intelligence Ltd)
- Implement a Balanced Scorecard for the Enhanced Home Based Support Services by 31 July 2013. The scorecard will incorporate four perspectives: client; learning and growth; business processes; and financial
- Develop a model through the Stakeholder Working Groups for alternative services for acute care and rehabilitation in the community using Home-Based Support Services, Age Related Residential Care, and community rehabilitation teams
- Monitor services for older people living at home to reduce acute admission and readmission, including rapid response and discharge processes through a community transition service using the enhanced Home Based Support Service
- Benchmark readmission rates for people over 65 years, and for Māori and Pacific people over 55 years living in the Auckland DHB area

Comprehensive Clinical Assessment

- Establish a joint Auckland DHB/Waitemata DHB aged residential care interRAI provider forum to provide feedback to the National InterRAI Project Team
- Ensure close collaboration with the National and Northern region governance group for interRAI in the development of local solutions
- Support the national interRAI training programme within aged residential care

Dementia Care Pathway

- Implement the Dementia Care Pathway across the health continuum including community, primary care, secondary care and aged residential care, by June 2014
    - Finalise pathway using a co-design model (quarter 1)
    - Prepare a commissioning report (quarter 2)
    - Finalise implementation plan (quarter 3)

Community Specialist Health of Older People Teams

- Proactive use of Specialist Health of Older People Teams (geriatricians, gerontology nurse specialists, nurse practitioners etc.) to advise and support health professionals in primary care and Age Related Residential Care
- Establish a 'baseline for 'inappropriate' admissions (i.e. where an older person is simply observed rather than given an intervention) to hospital from the community or from Age Related Residential Care
- Develop options to ensure enrolled people in Age Related Residential Care have access to GPs 24 hours a day, seven days a week

Elder Abuse Guidelines

- Implement the Ministry of Health Elder Abuse Guidelines
    - Elder abuse stakeholder group established (quarter 1)
    - Elder abuse implementation plan developed (quarter 3)

Fracture Liaison Service

- Deliver secondary preventative care for fragility sufferers (through identification, investigation and intervention) to prevent hip fractures. This will be supported by the minimum data set (MDS) for hip fractures (Service Level Agreement in progress)
    - Fracture clinic research project – retrospective analysis of patients with fractures completed by December 2013

How will we know we've achieved it? Measured by

Quality home and community support services for older people:

- All contracted home and community support service providers hold a certificate of conformance with the HCSS Standard NZS 8158:2012 by 1 September 2013
- Baseline for home and community support services core quality measures established and benchmark with other DHBs completed, by June 2014
- A model for alternative services to acute care is developed by 31 July 2013, and a pilot is completed by 30 June 2014
- Review of rapid response and discharge management services completed, by 30 June 2014
- Readmission rates for people over 65 years of age tracked and recorded.

Comprehensive Clinical Assessment in Age Related Residential Care

- 100% of Age Related Residential Care facilities in our district are using, or training their nurses to use, the interRai Long Term Conditions assessment tool by 30 June 2014

Dementia Care Pathway

- The Dementia Care Pathway will be implemented by 30 June 2014

Community Specialist Health of Older People Teams

- A total of at least 500 Nurses and Health Care Assistants from Age Related Residential Care will attend dedicated specialist training provided and funded by Auckland DHB
- A total of at least 600 Age Related Residential Care residents are case-managed or provided with a consult and liaison by Auckland DHB Gerontology Nurse Specialists

Community and Primary Care

- Baseline for inappropriate admission established

Elder Abuse Guidelines

- Ministry of Health Elder Abuse Guidelines implemented by 30 June 2014

Fracture Liaison Service

- Fracture Liaison Service established and functioning by June 2014.

3.6 Living within our Means

What are we trying to do?

Continue to be a financially sustainable and a productive organisation through continuous improvement and innovation that will deliver improved health outcomes, reduce inequalities and the burden on those most vulnerable within our community. We also commit to deliver our budget initiatives for the 2013-14 year.

Why is this important for community and patients?

As in previous years, we are operating in a financially constrained environment, where demand and growth for our health services is growing at a faster rate than our health funding.

The health service demand growth for Auckland DHB is particularly an issue as it is one of the largest DHBs in New Zealand, the third fastest growing of all DHBs, it has the most diverse population, and where 34% of the population live in areas that are most deprived. In addition, the pressure and demand to deliver secondary and tertiary services for other regions' populations is also a significant factor. In some services the growth is substantially higher than the growth of our population, particularly in cancer and in heart disease, which remains the biggest health problem area for our DHB.

DHBs have a role to ensure that the burden of health costs is spread fairly across our community and across generations. This can be achieved through sustainable financial and operational performance and ensuring capital investments required to sustain services are undertaken timely and in an affordable manner.

The 2012-13 business transformation and savings programme has been a key strategy for the DHB to continue delivering key health services in a fiscally responsible and financially sustainable manner. This strategy is based on the realisation that funding for the health sector is likely to continue to be constrained and insufficient to meet the growing demand for services and labour and inflationary induced cost pressures. This creates an imperative for the DHB to deliver services in a more efficient and smarter manner in order to live within its means.

The challenge is for continuous innovation and transformation. This is crucial to meet the growth in health needs of our community and at the same time live within our means. It is imperative that we continue to review closely how we do business and how we deliver services in order to operate more efficiently, more cost effectively and achieve more for our patients with lesser resources in all areas of our business.

Progress to date

At the start of the 2012-13 financial year, the DHB embarked on a major business transformation programme that would deliver savings from improved efficiencies and through innovation and changes in systems and processes. The year end forecast

financial position is a break-even operating surplus of $0.3m which will be due in part to the realisation of transformation savings of across the organisation.

Strategies that have contributed to our savings programme thus far include:

- Working with healthAlliance in streamlining inventory management system and supply contracts
- Working with Health Benefits Ltd on national procurement savings
- Funder contracts review, and value for money strategies
- Implementing new skill-mix models of care
- Developing a clinician-led programme to review models of care
- Developing a production plan to inform budget process for capacity and demand
- Reviewing staff skill mix, rostering and recruitment strategies to develop nurse model of care
- Collaborating with Waitemata DHB to drive efficiencies
- Improving processes to reduce waste and duplication
- Linking to primary care network to improve integration between primary and secondary that will achieve a better inpatient outcome

How are we going to do it? (Key planning approach)

- The business transformation programme will continue through to 2013-14 and beyond. The principles and focus on transformation will benefit our local population and people from other DHBs
- Introduce innovations through models of care and skill mix reviews to improve service efficiencies and increased productivity
- Continue to improve patient outcome with best practice and benchmarking strategies
- Continue to work with shared services healthAlliance and Health Benefits Limited to improve inventory control, purchasing and procurement of equipment, clinical and non clinical supplies
- Work collaboratively with primary care and NGO sector to improve transfer of care between primary and secondary services
- Work collaboratively on regional activities that will deliver tangible benefits as a result of working together in a cost-effective manner
- Work closely with Waitemata DHB to improve the delivery of health outcomes and efficiencies for both DHB populations
- Continue to review non-clinical operations to achieve efficiencies and savings
- Continue to contain growth of management/administration FTE to ensure resources are focused on frontline staff
- Maintain a long-term capital asset management plan to meet the increased demand over the next 20 years
- We also commit to deliver government's Budget 2013 initiatives

Specific deliverables/actions to deliver improved performance

- healthAlliance savings for inventory management and procurement of direct and indirect treatment costs underway
- Health Benefits Ltd savings programme underway for Finance, Procurement and Supply Chain, and for other national initiatives
- Implement skill-mix for the nurse model of care
- Implement clinical models of care and patient pathways that link the primary/secondary service integration e.g. using new technology
- Review of Allied Health delivery model underway
- Auckland and Waitemata DHB collaboration workstreams underway
- Review of outpatient clinics underway
- Service reviews underway in Labs, Pharms and other operational areas
- Community Pharmacy prescribing review underway
- Infrastructure costs review underway
- A review of funder contracts is underway along with a value for money programme

How will we know we've achieved it? Measured by

- Breakeven financial position achieved for 2013-14 and beyond
- Business Transformation savings of $38.8m achieved in 2013-14
- Specific business transformation initiatives implemented and savings monitored by year end
- A Production Plan in place that reflects demand and the needs of our local population as well as services required by other DHBs
- Evidence-based research on best practice and benchmarking developed to inform changes to models of care and FTE resourcing of these
- New models of care and skill-mix reviews developed and implemented in 2013-14
- Collaboration with Waitemata DHB scoped and workstreams implemented by July 2013
- Productivity initiatives deliver improved efficiency and effectiveness
- Regional workstreams implemented in 2013-14
- Inventory management and procurement savings led by support service agencies healthAlliance and Health Benefits Ltd realised in 2013-14
- Workstreams between the DHB and primary care/NGO sector scoped, savings and/or other benefits identified and implemented in 2013-14
- Maintaining the capped FTE levels agreed in the Annual Plan for non clinical staff.

3.7 Priority Populations

3.7.1 Māori Health

What are we trying to do?

Improve the health of the Māori population across Auckland and Waitemata DHBs, and to ensure Māori receive the best possible care. Specifically we aim to reduce the impact of modifiable risk factors known to impact on Māori health including smoking prevalence, obesity and the early onset of chronic ill health.

We also seek to ensure Māori wellbeing is maximised by working with Māori partners, including iwi and local Māori providers in a framework which is responsive to Māori health needs. We aim to ensure full access to our services, equitable treatment through our services and the elimination of health outcome inequalities.

Why is this important for community and patients?

There is substantial scope to improve health gain for Māori. By focusing on risk factors we can reduce their impact on health outcomes such as cancer, cardiovascular disease and diabetes. By ensuring we use a framework that is responsive to Māori and aligned to tikanga best practice we ensure our services are culturally appropriate.

Progress to date

Māori health inequality in health access has been eliminated from the emergency department, from immunisation and from breast screening. Māori nurse specialist roles have been appointed across Waitemata DHB to work specifically with Māori.

Progress against targets (Māori target in 2012-13)

- PHO enrolment (Māori): WDHB 75%, Auckland DHB 79% (97-103%)
- ASH Rates for Māori:

0-74	WDHB 100%	ADHB 106%	(WDHB >106%, ADHB >98%)
0-4	WDHB 86%	ADHB 72%	(>95%)
45-65	WDHB 99%	ADHB 113%	(WDHB >118%, ADHB >109%)

- More heart and diabetes checks: WDHB 68.3%, Auckland DHB 53% (75%)
- Breast screening: WDHB 66.1%, Auckland DHB 68.4% (70%)
- Cervical screening: WDHB 52.3%, Auckland DHB 57.1% (80%)
- Better help for smokers to quit (hospital): WDHB 96%, Auckland DHB 93% (95%)
- Better help for smokers to quit (primary care): WDHB 35.7%, Auckland DHB 37.1% (90%)
- Māori fully immunised at 8 months: WDHB 88%, Auckland DHB 85% (85%)
- Influenza vaccinations for Māori aged 65+: WDHB 56%*, Auckland DHB 58%* (70%)
- Rheumatic fever rates: WDHB 2.3, Auckland DHB 3.5 (WDHB 2.0, Auckland DHB 3.2)

**Data includes high needs population, which includes Māori, Pacific and NZDEP quintile 5*

How are we going to do it? (Key planning approach)

The key approach for the DHBs is to focus on activities that achieve Māori health gain through the application of the ORA framework. ORA stands for:

- **O**ptions for care
- **R**ight to quality care
- **A**chieving health gain

The framework focuses activity to eliminate barriers to access for Māori, and ensures all services provide the best quality care for Māori. Once access and quality issues are addressed, health gain will be achieved for Māori. To identify these issues, we will work with providers and communities, whose feedback we value in service improvement.

In addition to our own framework, we will rely heavily on partnerships and support from providers (both Māori and non-Māori providers) at the coalface to achieve our targets, whilst we ensure they achieve their own priorities.

Specific actions to deliver improved performance

Access to primary care

- Collaborate with PHOs to implement all three stages of the Ministry of Health Ethnicity Data Audit Toolkit in general practices
- Work with PHOs to ensure that the quality of ethnicity data at PHO level is high. (i.e. address issues with Datalink)
- Collect and analyse information about the conditions driving ASH rates in the 45-64 year age group

Chronic conditions

- Implement and develop specific Māori clinical positions across the DHB (WDHB only)
- Support the development of alternative settings for workplace CVD risk assessment and management
- Finalise and report the findings of clinical quality audit of Māori referrals for angiography and angioplasty, and develop a business case to support the implementation of recommendations
- Review the quality of ethnicity data within the mammography screening programme
- Develop data sharing protocols between PHOs and BreastScreen Aotearoa
- Fund Waitemata DHB PHOs for 2,200 priority group cervical screens and monitor the service closely
- Implement the priorities of the Auckland Metro Cervical Cancer plan for Māori women and whānau

Smoking cessation

- Develop a wraparound campaign with maternity services for pregnant Māori mothers which includes smoking cessation as part of a holistic health lifestyle programme
- PHO Smokefree coordinators will develop smoke free plans with specific activity to decrease Māori smoking rates

- Ensure that new contracts have a requirement for smokefree policy development
- Provide training so Māori Health Service/He Kamaka Waiora Registered Staff can be smoking cessation leads using the STEPS programme, with ongoing support through the Waitemata DHB Smokefree Team

Health of older people

- Develop a Kaumatua Strategy for Waitemata and Auckland DHBs
- Identify eligible patients who have not had a flu vaccine and offer vaccination
- Complete a review of older adult services purchased and provided by the DHB, by December 2013, and commence implementation of any recommendations by February 2014
- Look at the feasibility of running Marae-based seasonal influenza clinics, targeted around established Kaumatua networks, in partnership with Māori health provider general practices
- Promote free seasonal influenza for Māori over 65 years through the Needs Assessment and Service Coordination service, and Home Based Support Services
- Implement the I-Management Action Plan (IMAP) assessment and management tool across older adult services for the assessment, coordination, and discharge of older Māori

Child health

- Monthly analysis of the ten poorest performing practices (by ethnicity) and coordinate a response by the immunisation quality team
- Support the implementation of the Waitemata DHB and Auckland DHB Acute Rheumatic Fever programmes
- Ensure Māori providers are represented on the steering group and in the planning and implementation of the rheumatic fever strategy
- Support the capacity of Māori providers to participate in the delivery of the programme

Māori workforce development

- Develop a clinical leadership governance structure for Māori
- Support the Kia Ora Hauora initiative to support young Māori into careers in health through the Rangatahi Programme
- Recognise accredited whānau ora workforce training as an option for Hauora Māori support
- Undertake a stocktake of current workforce development activity across the DHBs
- Identify and prioritise opportunities to increase the Māori regulated workforce

How will we know we've achieved it? Measured by

Achieved the following national Māori health targets:

- PHO enrolment (Māori): 97-103%
- ASH Rates for Māori aged:

  0-74 WDHB >106%, Auckland DHB >98%

  0-4 >95%

  25-65 WDHB >118%, Auckland DHB >109%

- More heart and diabetes checks: 90%
- Breast screening: 70%
- Cervical screening: 80%
- Better help for smokers to quit (hospital): 95%
- Better help for smokers to quit (primary care): 90%
- Māori fully immunised at 8 months: 90%
- Influenza vaccinations for Māori aged 65+: 70%
- Rheumatic fever rates: WDHB 2.0, Auckland DHB 3.2

Key Māori clinical leadership positions in place

Review of older adult service completed and recommendations implemented.

3.7.2 Pacific Health

What are we trying to do?

Increase Pacific access to health care, improve the quality of care they receive and thereby improve Pacific health outcomes and reduce health inequalities for Pacific. We also need more people engaged in this effort: we want Pacific people to have good health literacy, communities and churches active in solving health problems, culturally competent clinicians, and more Pacific people training for careers in health.

Why is this important for community and patients?

There is a difference of 8 years in life expectancy between Pacific people and Non-Pacific Non-Māori people in our community. Coronary heart disease, lung cancer, diabetes, obesity and stroke account for over half of this difference. In order to reduce the inequalities experienced by our Pacific population, it is important that we work towards meeting the health targets across the board for all our population groups.

All health services, at every point in the continuum of care, need to engage with expertise with their Pacific patients and their families, and make sure that health care experiences are always positive.

Progress to date

- National health targets for immunisation, support to quit for hospitalised smokers and breast screening are being met by Auckland DHB
- In addition, the More Health and Diabetes Checks target of 60% by June 2012 was met by Auckland DHB, achieving 65%
- In terms of annual diabetes checks, Auckland DHB achieved a coverage rate of 68%
- 60% of Auckland DHB people had well-managed diabetes
- The establishment of one Pacific Planning and Funding Team across Auckland and Waitemata DHBs

How are we going to do it? (Key planning approach)

- Focus on moving interventions "upstream"
- Engage service users in the re-design and review of current services to improve the "health literacy" of the Pacific population and improve the Pacific cultural literacy of non-Pacific health workers
- Strengthen our community action programmes of Healthy Village Action Zones to improve health literacy, linking Pacific people to services, and driving initiatives that are focused on health and wellbeing
- Strengthen collaboration with other organisations that address lifestyle issues such as regional sports organisations
- Establish formal referral pathways between Pacific whānau ora providers and Pacific and other primary care providers
- Engage Pacific service users in the exploration of the relevance of 'self-directed care' to Pacific individuals and families
- Strengthen the working relationship with Counties Manukau DHB. Learn and adopt any interventions they have found to be effective in addressing the common challenges we face
- Formalise relationships between DHBs, Ministry of Social Development and Early Childhood Education, and collaborate in areas where we have common objectives, specifically in relation to child health and support for parents and grandparents
- Diabetes self-management education (DSME) workshops will continue to be delivered
- The links between the nurse led/multi-disciplinary team clinics and GP practices with high Pacific enrolment will be strengthened
- The Pacific PHO and Pacific GP practices will actively participate in the work of the northern regional diabetes network and in the development of service delivery models. This ensures that models respond to the specific issues experienced by Pacific people with diabetes, and there is a significant improvement in the number of people with well managed diabetes
- Services to support access to screening programmes will be maintained
- Pacific people will be supported to access bariatric surgery where they meet the criteria
- Align the Pacific focused activities of services across Auckland and Waitemata DHBs and oversee progress, providing advice as required
- Develop and support Pacific clinical leadership with more Pacific Best Practice training across both DHBs
- Develop Pacific staff networks that can do more to support our Pacific health workforce, their activities and initiatives

Specific actions to deliver improved performance

- A Joint Waitemata/Auckland DHB Pacific Action Plan (incorporating the strategic direction and actions) will be developed

- Self Management Education and Diabetes self-management education will be delivered to Pacific communities in Auckland DHB. The Self Management Education programme will be translated into Tongan
- Work with Alliance Health+ to improve and design integrated and seamless maternity services targeting Pacific women in Auckland DHB
- Systematic recall of all eligible Pacific people to a nurse led clinic
- Health education / promotion and support services to engage with breast, cervical and bowel screening programmes will be maintained
- Monthly meetings with Counties Manukau DHB will occur and any successful strategies and interventions for their Pacific population will be adopted, especially in relation to diabetes and cardiovascular disease
- Alliance Health+ participation in Auckland DHB local health partnerships
- One Pacific Planning and Funding Team across Auckland and Waitemata DHBs
- A programme specifically for the parents of Pacific youth will be developed in conjunction with other services

How will we know we've achieved it? Measured by

- 90% of Pacific children are up-to-date with their immunisation at 8 months
- 95% of Pacific children will be up-to-date with their immunisation at 24 months
- Five year heart and diabetes check completed by general practice/nurse led clinics for 90% of the eligible Pacific population by 30 June 2014
- 76% of eligible Pacific population will achieve good diabetes management
- 90% of enrolled Pacific patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking
- Maintain Pacific participation in breast screening programme at 75% or higher
- Increase Pacific participation in bowel screening programme (WDHB)
- Increase Pacific participation in cervical screening to 75%
- Increase number of Pacific youth receiving services from the Youth Hub
- 95% of Pacific inpatients surveyed report their experience as excellent or very good.

3.7.3 Asians, Migrants and Refugees

What are we trying to do?

To improve the overall health status of the Asian/ Middle Eastern, Latin American and African (MELAA), new migrant and refugee populations living in Waitemata and Auckland districts. Continue the focus on areas of high need, and strategies to overcome barriers, e.g. language and staff cultural competency.

Why is this important for community and patients?

It is expected that all New-Zealanders regardless of ethnicity receive an equitable level of health service access and care. Some Asian groups living in Waitemata and the Auckland region have high health needs and experience disparities in health service access, particularly in relation to PHO enrolment, cervical screening, mental health, and chronic disease (including diabetes and cardiovascular disease). The term Asian refers to the

ethnic groups of Chinese, Indian, Southeast Asian and other Asians. For reporting purposes, most indicators in this section are for the Asian population as a whole.

Progress to date

We have continued to implement the Waitemata DHB Asian Health Action Plan. Key achievements include:

- 74% Asian PHO enrolment rate
- 70% of Indian population had an annual diabetes review
- Childhood immunisation rates at age 2 years exceed the national target of 95%
- 61% (December 2012) cervical screening rate for Asian women
- Access to Primary Health Interpreting Service exceeded target by 20%
- Enrolment for on-line CALD (Cultural and Linguistic Competency) training, exceeded target by 85%

How are we going to do it? (Key planning approach)

- Continue to implement the Auckland Regional Settlement Strategy, Migrant Health Action Plan
- Continue to work alongside Waitemata Asian PHO Enrolment Working Group (Auckland DHB has an observing role in the group)
- Review the structure and resource for Asian, migrant and refugee health

Specific actions to deliver improved performance

- Expectations for increased access to cardiovascular and diabetes risk assessment services through general practice and inpatient services will be reflected in PHO contracts and Provider Arm Service Level Agreements
- Northern Regional Diabetes Network indicators used as measurement tools by quarter 4

How will we know we've achieved it? Measured by

- Increase efforts to get the Asian PHO enrolment rate from 74% up to the target of 95%, by June 2014
- 90% of eligible Indian and other Asian people (grouped to include Chinese, Southeast Asian and Other Asian) will have had a heart and diabetes check within the last five years, by 30 June 2014
- 65% of Indian and other Asian people (grouped to include Chinese, Southeast Asian and Other Asian) will receive the Diabetes Care Improvement Package over the year to 30 June 2014
- Northern region diabetes network indication outcomes will be consistent for Asian people and all other people
- A minimum of 65% of Indian people with diabetes will have an annual review
- Increase regional Culturally and Linguistically Diverse (CALD) 1 online course enrolments by 700 based on 2012-13 utilisation
- 10% increase in the use of Primary Health Interpreting services over the 2012-13 rate
- Achieve 90% immunisation rate for Asian 8 month olds, by June 2014.

3.8 Patient Experience and Quality

3.8.1 Patient Experience

What are we trying to do?

Work together with patients and families to:

- Develop a culture of trust and power sharing with the population and between care partners
- Empower patients, so that health care and its outcomes lead to enhanced quality of life

Why is this important for community and patients?

Increasingly, there is evidence that quality is affected not only by the quality of technical care received, but also by the quality of interpersonal relationships (e.g. staff, patients and families). There is also increasing evidence that good patient experience and good clinical quality going hand-in-hand.

Progress to date

- Initial 'Patient and Family Centred Care' current state assessment completed
- Case-studies in 'Patients and Families as Partners in Care' undertaken
- Complaints process reviewed
- Participation in the Health Quality and Safety Commission's 'Partners in Care' programme
- All Severity Assessment Code (SAC) 1 and 2 adverse events are reviewed and recommendations communicated to relevant stakeholders. However, open disclosure of review findings to families has not been consistently applied
- Advanced Care Planning (ACP): We have developed patient and clinician tools and resources to increase awareness and encourage conversations. Advanced Care Planning training including advanced communication training is well established and 66 Auckland DHB staff members have attended the Level 2 Practitioner training. We have seen an encouraging increase in the number of meaningful conversations taking place with patients particularly in Renal, Heart Failure, Neurology, COPD and Health of Older People
- Advance Care Planning training completed by 36 staff in 2012
- End of Life Care project commenced
- Experience-based co-design integrated into Greenbelt training programme
- We have established 'Local Health Partnerships' to engage community representatives in Glen Innes, Maungakiekie-Tamaki, Puketapapa and Great Barrier Island. Discussions have been initiated to explore opportunities for Local Health Partnerships on Waiheke Island and in the Albert-Eden, Orakei and Panmure wards

How are we going to do it? (Key planning approach)

- Continue the development of a 'Patient, Family and Community Engagement Framework' to integrate and guide hospital and community based engagement activity

- Engage patients and the community to improve services including co-design programmes and involving patients and community representatives in project teams
- Collaborate with sub-regional and regional DHB colleagues and the Health Quality and Safety Commission's 'Partners in Care' programme
- Work with the NGOs, private sector, AUT and the Health Quality and Safety Commission to develop organisation capability to improve consumer experience

Specific actions to deliver improved performance

- Patient and Family-Centred programme developed, by Dec 2013
- Implement complaints review recommendations by Dec 2013
- Implement updated Visitation Policy, allowing patient-directed visitation, by June 2014
- Develop a 'Care Partner' policy and pilot 'Care Partner' agreements in 2 wards by June 2014
- Implement service improvements in Cardiology transition co-design project by December 2013
- Re-design of Auckland City Hospital 'front door' experience by June 2014
- Upgrade signage to improve way-finding across Grafton and Greenlane sites by June 2014
- Experience-based co-design professional development/ education module developed by December 2013
- Training in Patient-based communication values, skills and techniques developed by June 2014
- Work with healthAlliance to establish the IT infrastructure for the capturing and sharing of Advance Care Plans across the care continuum
- Review and amend policy about open-disclosure for all major adverse events to clarify expectations and process for disclosure to patients and families
- Improve response rate to the Patient Experience Survey so that profile of respondents more accurately reflects our population, by June 2013
- Increase percentage of patients attending ambulatory services receiving a copy of their clinic letter from 20% to 70% by June 2014

How will we know we've achieved it? Measured by

- Percentage of Patient Experience Survey respondents rating 'Communication', Quality of care', and 'Care Coordination' as 'Very Good' or 'Excellent' increases to 85% from 81%, 82% and 82% respectively, by June 2014
- Percentage of Patient Experience Survey respondents rating their overall experience as 'Very Good' or 'Excellent' increases from 82% to 90% by June 2014
- Percentage of patients rating the complaints resolution process as 'Excellent' increases by June 2014
- 100% of all patients/families impacted by Severity Assessment Code 1 or 2 will have open disclosure of the facts, including review findings, by Oct 2013.

3.8.2 Quality

See also patient experience section.

What are we trying to do?

Create a health system which delivers high quality health care, reduces avoidable patient harm, improves effectiveness and increases patient quality outcomes.

Why is this important for community and patients?

We need to continuously earn the trust placed in us by our community by insisting on quality and striving to get the basics right first time, every time.

Patients and families need to:

- be confident of the quality and safety of the care they will receive
- know that the care they receive is best practice and evidenced based

There is increasing evidence that the more involvement a patient and their family / whānau have in their care, the greater the increase in the safety and quality outcomes of that care.

Designing patient centred systems and processes that are capable of improving patient flow, outcomes and experience, and clinically led continuous quality improvement, will drive patient centred improvement in care and will enable patients, employees and the community to receive the type of health service they need.

Progress to date

A regional approach to safety through collaboration of the 'First Do No Harm' projects

- Falls (reducing by 20%)
- Pressure injuries (reducing by 20%)
- Hand Hygiene (compliance to 70%)
- Central Line Associated Bacteraemia (CLAB) reducing by 40%

Implementation of an end of life strategy including

- Advance Care Planning
- Bereavement programme

Improving service excellence

- Reducing the waiting times in Emergency Department
- Patient flow programme
- Concord quality improvement programme
- Dementia care pathways
- Reduction in time to Cancer First Specialist Assessment

How are we going to do it? (Key planning approach)

- Collaborate with sub-regional and regional DHBs, colleagues and the Health Quality and Safety Commission's patient safety programme and consumer experience programme
- Staff engagement
- Increase capability and capacity of staff through Green belt and fundamentals improvement training programme
- Increase capability and capacity of staff through Patient Smart and quality improvement specialist education and training programmes
- Implementing a portfolio of improvement projects
- Clinical audit and research activities

Specific actions to deliver improved performance

- Actively participate in the regional 'First do no Harm' project:
  - research and design a project for the improvement of community acquired fractures
  - implement a process to rate all grade 3 and 4 pressure injuries to SAC 2
- Research and design a project for mis-identification events
- Write and publish quality account
- Development of a safety management system
- Auckland DHB and Waitemata wide key process risk assessment
- Continued roll out of the surgical performance improvement programme
- Implementation of a clinical governance framework
- Deploy Advance Care Planning programme
- Develop a patient and family centred approach to care delivery
- Develop and implement an organisation wide approach and system to clinical and non-clinical audit
- Implement an out patients survey
- Implement an experienced-based design programme
- Co-design to be highlighted as part of the patient and family centred programme

How will we know we've achieved it? Measured by

- 90% of patient's aged 75 and over (Māori and Pacific 55 years and over) are given a falls risk assessment
- 70% or higher compliance with good hand hygiene practice
- 90% compliance with central venous line insertion bundles
- 90% compliance with central venous line maintenance bundles
- 90% of operations where all three parts of the surgical checklist were used
- Public reporting of credentialing details of senior doctors, all findings and recommendations from serious and sentinel event investigations (in the public section of board reports), and improvements in patient experience
- The completion and presentation of:
  - an Audit data base
  - a Quality account.

MODULE 4: Managing our Business

In order to effectively and efficiently deliver the priority actions described in modules 2, 3 and 5, we must put high level strategic planning into action. The DHB needs a supportive infrastructure to achieve this. Some of the key enablers that help us manage our business are covered below.

We must also operate in a financially responsible manner and show accountability for the assets we own and manage. We must ensure that every public dollar spent is spent wisely with the overall intention of improving, promoting and protecting the health of our population.

4.1 Building Capability

We will achieve the outcome of 'living within our means' by:

- Aligning with Health Benefits Ltd projects
- Developing appropriate risk management and reporting
- Improving the performance and management of assets
- Controlling the purchase of provider arm services using a price volume schedule

In 2013-14 we will establish formal accountability and reporting lines for each of the activities above.

- Alignment with Health Benefits Ltd projects will require regional collaborative mechanisms to be put in place.
- The management of risk, assets and purchases will largely be intra-DHB, with reference to neighbouring DHBs as necessary (e.g. Interdistrict flows in the Price Volume Schedule)
- Specific actions to deliver improved performance include:
    - manage Price Volume Schedule to balance demand/need to capacity
    - report risks on a monthly basis
    - Identify and report on asset management improvement objectives and asset management
    - coordinate Health Benefits Ltd activities
    - achieve all Ministry of Health targets/indicators of DHB performance

To date we have successfully aligned risk management and reporting between Auckland DHB and Waitemata DHB including policies, procedures and risk management tool. We will continue to develop innovative ways to support the service delivery changes needed. Improving the effectiveness and efficiency of 'in-house' tasks frees resources for health care delivery.

4.2 Building IT Capacity

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

The Northern Region Information Strategy (RIS10-20) and the Northern Region Information Systems Implementation Plan set the direction for information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for Auckland DHB to achieve clinical and business objectives.

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

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

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

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

Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and the investment in our future systems.

In addition to the investment in core infrastructure and IS support processes, Auckland DHB, as part of the Northern Region, will continue to implement the National and Regional Information Strategy. Auckland DHB has prioritised the following projects:

Electronic Solutions to Support Safe Medication Management. Auckland DHB supports the national eMedicines programme and will implement electronic medicines reconciliation and pilot ePrescribing in secondary care.

Single Clinical Workstation: The region will progressively standardise on a single clinical workstation. This will provide a consistent user experience, improve clinical communication and reduce the complexity of integration and audit functions. Auckland DHB will support the development of the business case for the Regional Clinical Workstation.

Continuum of care: Auckland DHB will implement eReferrals phase 2 (including triage, intra and inter DHB referral functionality)

Regional Clinical Data Repository: The regional clinical data repository has been implemented and further enhancements are planned to support continuity of care, including:

- Northland DHB access and contribution to the repository
- improved primary care access
- implementation of Regional Clinical Documents Phase 2 to add more content from various clinical information systems

Clinical Support: Auckland DHB will:

- Implement 3M Chartview to replace the CRIS (clinical record information/scanning system)
- Complete the implementation of cardiovascular risk assessment tools for acute care (Acute Predict)
- Work with the Northern Region to complete the business case for eLabs (Laboratory Orders)
- Complete the business case for the Regional Oncology system

Patient Management System: Within the next eight years the region will implement a common patient management system for patient registration, scheduling, booking, transfer and discharge. The system will support the requirements of primary care for seamless integration and improved access to patient information. The scope will also include clinical/electronic patient record functionality.

Activities in 2013-14 will include selection of the preferred supplier for the Regional Patient Management System and completion of the stage 1 business case. The solution will align with and support Auckland DHB's strategic intent to adopt a Self Directed Care approach to empower people to take more control over their own health and well being and maximise their quality of life.

Population Health Data Repository: There will be a single source for regional population health information, potentially supported by a shared population health team. This will improve collection, quality, availability and sharing of population health data across DHBs and PHOs.

Auckland DHB will support the region to:

- establish Northern Region population health capability
- develop KPI reporting to support clinical networks focus on improving health outcomes
- confirm the regional population health dataset

Business Support: Key activities include:

- bedding down the Oracle R12 (Finance Procurement and Supply Chain) shared service system
- completion of the rostering system (RiTA) implementation
- establishing the regional Enterprise Content Management System platform and support capability

Shared Care Plan: New models of care depend on multidisciplinary teams working across primary, community and secondary care, together with the patient. A patient-centred clinical management system promotes integrated care, acute demand management and the empowerment of patients. The pilot phase has been completed. In this next period, the solution will be operationalised to support future version, process and scale upgrades. Auckland DHB will also complete the business case for the Patient Portal as part of our 'Digital by Default' strategy to connect with patients electronically.

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

4.3 Strengthening our Workforce Capacity

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

The Health Workforce New Zealand (HWNZ) and the Northern Regional Training Hub (NoRTH) priorities will be central components of strategies to be implemented. The work streams associated with each of the four workforce strategy elements are detailed in the DHB Workforce Strategy 2012-2016 document. These are aligned to the regional priorities established to support the achievement of the Regional Health Plan objectives as well as local priorities and requirements.

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

We will behaviourally define our values and include our staff and patients in this process so that our values and behaviours reflect what our patients want to see and experience. We will review our recruitment process to screen new recruits against the values and behaviours. Our position descriptions, recruitment practices and performance management processes will be aligned to reflect the organisation values and behaviours and embed a culture of accountability, respect and dignity.

Further development of local health heroes, staff recognition and reward programme will be implemented to reinforce the refreshed values and defined behaviours are being demonstrated in all areas of patient care and organisational activity.

Clinical leadership is at the core of all we do. Auckland DHB will expand on the leadership work commenced in the 2012-13 year in collaboration with the NZ Leadership Institute and implement joint opportunities with Waitemata DHB and Professor Richard Bohmer. Learning and development needs across the whole of the organisation will be reviewed to ensure that each specific clinical area has sufficient time and resources set aside for these activities.

We are aware of the 70/20/10 model for the allocation of postgraduate medical education funds, and our regional service plan takes account of this. Some of the metrics still need to be defined. In the meantime we will work collaboratively as a region with the training hubs and Health Workforce NZ to achieve these targets.

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

4.4 Quality and Safety

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

The plan for 2013-14 focuses on improving the patient experience, enhancing patient safety and increasing organisational capability regarding quality assurance and improvement. It is built on a foundation of clinical governance and is consistent with the recommended priorities from the New Zealand Ministry of Health, the Health Safety and Quality Commission and the Northern Region Health Services Plan. Specific actions are included in Module 3 'Patient Experience' and 'Quality'.

We also have responsibility under the New Zealand Public Health and Disability Act to monitor the delivery and quality of contracted services. We carry out this responsibility through a number of auditing agencies, as well as through ongoing relationship management undertaken by programme managers.

The contracts' manager coordinates the audits and receives and reviews the audit reports before passing them on to the relevant programme manager for review and follow up. Any critical issues are escalated if necessary and managed.

4.5 Organisational Health

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

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

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

- Recognise the aims, aspirations and employment requirements of Māori people
- Provide opportunities for individual employee development and career advancement.

4.6 Reporting and Consultation

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

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

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

4.7 Ability to Enter into Service Agreements

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

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

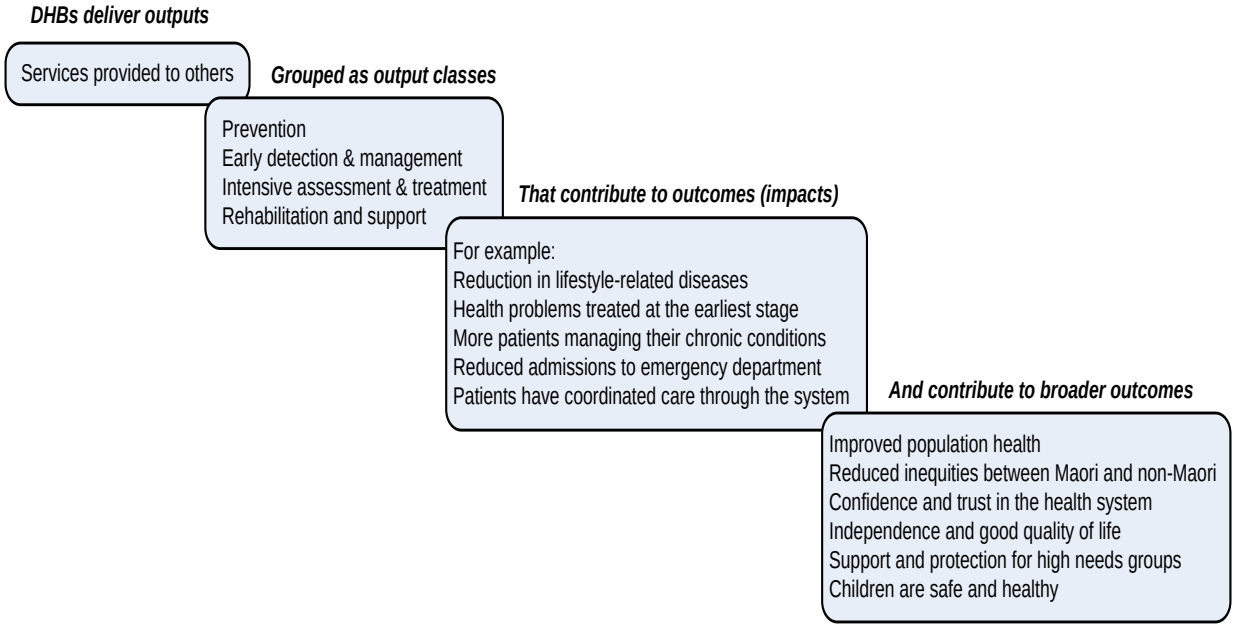
b) Negotiate and enter into agreements to amend service agreements.

MODULE 5: Forecast Service Performance

The statement of forecast service performance is a way of telling our 'performance story'. It provides the structure which explains *what* we are producing and *why* we are producing it. The statement of forecast service performance is a requirement of the Crown Entities Act 2004 and sections 39 and 42 of the NZ Public Health and Disability Act 2000. It identifies outputs, measures, and performance targets for the 2013-14 year.

A few cornerstone measures are chosen to cover the vast scope of business-as-usual activity. These provide a reasonable representation of the services provided by a District Health Board. They represent activities that deliver our goals and objectives in modules 2 and 3. They cover the quantity, quality and the timeliness of service delivery. Recent 'actual' performance data is used as the baseline for targets. Actual performance against these measures will be reported in our Annual Report, and audited at year-end by AuditNZ on behalf of the Office of the Auditor General.

Throughout the statement of forecast service performance, the logic framework describes the relationships between resources, activities, results (inputs, actions planned, outputs, expected impacts) and link to outcomes. It provides a common approach for integrating the planning, implementation, evaluation and reporting that occurs for our DHB. This logic framework articulates how the work of the DHB impacts on our performance, specifically how it meets the Government's health targets and other priorities. It also explains how planned activities will impact on the health of people living in our district under each Output Class.



The logic framework that underpins this Statement of Forecast Service Performance

Targets and Achievement

Our focus for 2013-14 is on making a positive impact on health outcomes; making sure people have a positive their experience of our health services; and using resources efficiently. Our actions in 2013-14 need to contribute directly to the outcomes we want over the longer term. The outcomes and impacts in this section link to the national, regional and local strategic direction covered in section 2 of this document.

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

When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was very close to target versus those where under-performance was more significant.

The criteria used to allocate these grades

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

Impacts are harder than outputs to measure, being the longer term end result of the immediate actions taken by a health service provider. Not all impact measures lend themselves to annual targets or even annual analysis. For audit purposes impacts are defined as: the contributions made to an outcome by a specified set of outputs. Often referred to as 'intermediate outcomes'. They represent the relatively immediate or direct effect on stakeholders of the entity's outputs.

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

Cost of Outputs

Auckland DHB Output Class Financial Plan for the Year Ending 30 June 2014 and outyears.

Year ending June 2014

New Output Class Name	Intensive Assessment & Treatment	Rehabilitation and Support	Early Detection and Management	Prevention Services	Total
	Plan 2014	Plan 2014	Plan 2014	Plan 2014	Plan 2014
Total Revenue	1,264,436	153,475	567,794	19,895	2,005,600
Expenditure					
Personnel	741,658	13,580	14,520	13,483	783,241
Outsourced Services	82,762	387	980	71	84,200
Clinical Supplies	229,190	3,034	1,106	224	233,554
Infrastructure & Non-Clinical Supplies	140,550	9,997	27,672	2,477	180,696
Payments to Providers	66,287	137,968	518,771	798	723,825
Total Expenditure	1,260,447	164,966	563,050	17,053	2,005,515
Net Surplus / (Deficit)	3,989	- 11,491	4,744	2,842	85

Year ending June 2015

New Output Class Name	Intensive Assessment & Treatment	Rehabilitation and Support	Early Detection and Management	Prevention Services	Total
	Plan 2015	Plan 2015	Plan 2015	Plan 2015	Plan 2015
Total Revenue	1,287,763	156,307	578,270	20,262	2,042,602
Expenditure					
Personnel	759,458	13,906	14,868	13,807	802,039
Outsourced Services	84,748	396	1,004	73	86,221
Clinical Supplies	234,690	3,106	1,133	229	239,159
Infrastructure & Non-Clinical Supplies	138,283	9,835	27,226	2,437	177,781
Payments to Providers	67,528	140,550	528,478	813	737,368
Total Expenditure	1,284,706	167,794	572,709	17,358	2,042,568
Net Surplus / (Deficit)	3,057	- 11,487	5,561	2,904	34

Year ending June 2016

New Output Class Name	Intensive Assessment & Treatment	Rehabilitation and Support	Early Detection and Management	Prevention Services	Total
	Plan 2016	Plan 2016	Plan 2016	Plan 2016	Plan 2016
Total Revenue	1,313,720	159,457	589,926	20,671	2,083,774
Expenditure					
Personnel	775,407	14,198	15,181	14,097	818,882
Outsourced Services	86,528	405	1,025	74	88,032
Clinical Supplies	239,619	3,172	1,157	234	244,182
Infrastructure & Non-Clinical Supplies	140,398	9,986	27,643	2,474	180,501
Payments to Providers	68,880	143,363	539,057	829	752,129
Total Expenditure	1,310,832	171,124	584,062	17,708	2,083,726
Net Surplus / (Deficit)	2,888	- 11,667	5,864	2,962	48

5.1 Output Class 1: Prevention Services

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

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

Prevention and health promotion services are delivered by many organisations across the Auckland region, including;

- Screening services such as BreastScreen Aotearoa (BSA)
- Directly by the DHB, for example through the community services arms of Child, Women and Family Services
- Public health services are largely delivered by the Auckland Regional Public Health Service (ARPHS). ARPHS is managed by Auckland DHB and provides regional public health services to the DHBs of the greater Auckland region. These services include health protection (environmental health, communicable disease control, and emergency planning and response), health promotion (healthy housing, alcohol & tobacco and nutrition & physical activity) and population screening (breast, cervical, preschool and newborn)
- A significant portion of the work of Primary Care is preventive in nature. Preventive outputs and activities provided by General Practice teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment output class.

Contribution to outcomes

Our population's health is improved through the delivery of **prevention services** as they reduce the amount and size of disease outbreaks and reduce the harm from environmental hazards. At an individual patient level they increase survival and reduce the morbidity from some cancers.

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

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

Output: Health Protection

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline (2011-12)	Target 2013-14 *(Auckland metro DHBs)*	Impacts
Communicable disease surveillance and control activities	Notifiable Infectious Disease: Receive, investigate and manage notified diseases	***Quantity*** Total number of communicable disease notifications per reporting period	Notifiable disease identification and investigation is an important component of the work of ARPHS and plays a major role in communicable disease control. These are indicators of the volume of output in this output class	6,785	6,250 est	Public health risk from vaccine preventable and notifiable communicable diseases is minimised **Impacts measured by** Rate of confirmed and probable notifiable communicable disease cases per 100,000 persons per year
		Number of notifications investigated and found to be a *confirmed or probable case*		5,214	5,100 est	
		Number of notifications investigated and found to be *not a case*		1,371	918 est	
		Quality Percentage of notifications with case status recorded	Case status will be recorded when investigation of a case has been completed and EpiSurv (the national surveillance database) has been completed	97%	≥ 95%	
Health Protection (Physical Environment) Environmental control activities including: air quality; border health protection; burial and cremation; contaminated land; water quality; hazardous substances; radiation; sewage; waste management; resource	Drinking water quality: Assess compliance with the Drinking Water Standards (DWSNZ)	***Quantity*** Number of DWSNZ Suppliers' Compliance Assessments conducted and reports completed	ARPHS promotes compliance with the Health (Drinking Water) Amendment Act 2007 and Health Act 1956 to optimise the safety and quality of drinking water available for public consumption in the Auckland region. This is an output measure	272	270 est	The incidence and impact on health of environmental hazards are reduced **Impacts measured by** Percentage of compliant water suppliers (not all suppliers are required by legislation to comply)
		Quality Percentage of reports provided to water supplier within 20 working days	There is a clear requirement under that Act to report water supplier compliance within 20 working days. This is a timeliness measure.	100%	100%	
	HSNO (Hazardous Substances and New Organisms) Investigation and management of lead	***Quantity*** Number of lead notifications received	Minimising the harm from hazardous substances is a key role of ARPHS. Lead possesses intrinsic toxicity and is considered as a hazardous substance under the HSNO Act.	133	150 est	Rate of elevated serum lead notifications resulting from non-occupational exposure
		Number of confirmed cases that occur as a		81	90 est	

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline (2011-12)	Target 2013-14 *(Auckland metro DHBs)*	Impacts
management.	related events	consequence of occupational exposure	ARPHS receives notifications of cases of raised blood lead levels and determines whether cases are either occupational or non-occupational. This is a measure of population exposure to lead as well as an output measure.			
		Number of confirmed cases that occur as a consequence of non-occupational exposure		30	30 est	
		Quality Proportion of cases with probable source identified	Source of lead poisoning is identified through the process of case investigation. Thorough investigation increases the potential of source identification. This is a quality measure.	84%*	≥85%	

This data is for all 3 metro Auckland DHBs

** It is not clinically possible to get 100% reliability in all cases, especially where exposure has been relatively low*

Output: Health Promotion

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline 2011-12	Target 2013-14 *Auckland metro DHBs*	Impacts
Health Promotion (Prevention of Alcohol and Drug Related Harm and Legislative and Leadership – Smokefree Environments Act 1990) Monitoring compliance with alcohol sales legislation	Alcohol Legislative Programme: Enforcement of Alcohol Legislation	***Quantity*** Number of licence applications risk assessed (on-licence* and club)	In order to minimise harm associated with the consumption of alcohol, ARPHS works to reduce the proportion of premises which sell alcohol that are of high or extreme risk. All on-licence and club-licence premises in the Auckland region are risk assessed. Extreme or high risk premises receive a pseudo-patron compliance check to ensure they are meeting their host responsibility obligations under the current liquor legislation. These are outputs and impact measures.	1,269 **	1,200 est	Auckland liquor retailers provide safe environments for responsible drinking. Reduced alcohol related harm **Impacts measured by** Percentage of licensed premises (on-licence and club) that have been assessed as high risk (baseline 2011-12 92% target ≥95%) Proportion of joint Controlled Purchase Operations in which alcohol is sold to minors
		Number of licensed premises (on-licence and club) assessed as high risk		608 ***	400 est	
		Number of joint Controlled Purchase Operations (CPOs) conducted		n/a *no baseline data. the risk assessment tool has just been implemented*	30%	
		Quality Percentage of premises risk assessed with overall risk rating recorded as per audit protocol	Controlled purchase operations monitor and enforce compliance with legislation. This indicator, by measuring compliance, offers a proxy for the likely impact of legislation and its enforcement on harmful alcohol consumption. These are outputs and impact measures.	237	200 est	
Health Promotion (Prevention of Alcohol and Drug Related Harm, Legislative programme and Leadership – Smokefree Environments Act 1990)	Smokefree Legislative Programme: Enforcement of the Smokefree Environments Act 1990	***Quantity*** Number of retailer compliance checks conducted	Compliance checks are conducted with tobacco retailers to ensure they are meeting their obligations under the Smokefree Environments Act 1990	571	500	Smoking related mortality and morbidity is decreased in Auckland **Impacts measured by** Proportion of tobacco retailers who are compliant (Baseline 2011-12 82%, target
		Number of Controlled Purchase Operations (CPOs) conducted	Preventing minors from accessing tobacco products contributes towards the prevention of smoking initiation. These are outputs and impact measures.	498	500 target	

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline 2011-12	Target 2013-14 *Auckland metro DHBs*	Impacts
Monitoring compliance with Smokefree legislative programme		***Quality*** Outcome of operation is recorded as per audit protocol	Failure to comply with protocols would reflect a problem with quality.	82% *(2012-13 data)*	≥85% est	85% est) Proportion of Controlled Purchase Operations in which tobacco is sold to minors

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

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

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

Output: Health Policy / Legislation Advocacy and Advice

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

Output: Population Based Screening

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Population breast screening of women aged 45-69 years	Eligible women screened for breast cancer	***Quantity*** Screening coverage rates among eligible groups	Coverage is a standard measure of output from screening programmes	69% *(2 yrs to end of Dec 2012*)	68%	70%	70%	Increased survival / reduced mortality from breast cancer **Impacts measured by** Imputed years of life gained among Auckland domiciled women through breast screening
		Quality Breast screening - Proportion of women screened who report that their privacy was respected	Reflects the quality of the service	97% Q2 2013-14	96.1%	95% *	95%	
		Timeliness Proportion of women screened who receive their results within 10 working days	A timely service provides test results promptly	96.4% 2012 calendar year	96.9%	95%	95%	
Newborn hearing screening	Eligible newborns screening for hearing	***Quantity*** Number/proportion of babies screened	Coverage is a standard measure of output from screening programmes	7810 (96.31%) *Dec '11 to Nov 2012*	n/a	100%	n/a	Hearing loss is identified by 12 weeks of age for >=95% of children referred to audiology by the screening programme.
		Quality Referral rate to audiology <=4%.	Reflects the quality of the service	1.6% *Dec 2011 to Nov 2012*	n/a	<=4%.	n/a	
		Timeliness Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme	A timely service provides prompt access	100%	n/a	>=95%	n/a	

NB. Outputs and Activities provided by General Practice Teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class. A significant portion of the work of Primary Care is preventive in nature.8

** The targets for Breast Screening are set by the National Screening Unit so where our baseline is higher, we are exceeding the target*

5.2 Output Class 2: Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings.

These include general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are, by their nature, more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services which focus on individuals and smaller groups of individuals.

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

Contribution to outcomes

Ensuring good access to **early detection and management services** for all population groups helps to reduce disparities and improve population health. This work includes prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions, and giving consideration to health disparities in the prioritisation of service mix. Early detection and management services also enable patients to maintain their functional independence and prevent relapse of illness.

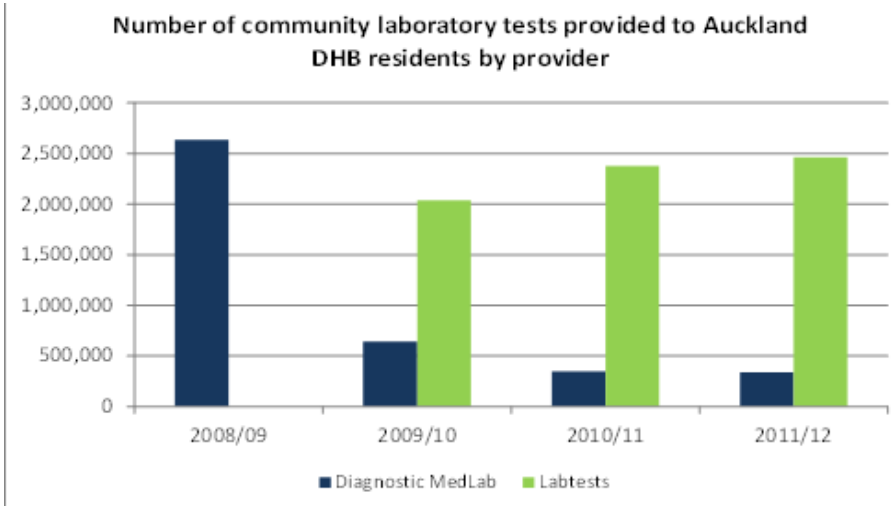
Our patients' experience is improved through timely access to services, reassurance in the case of negative results and prompt management of complaints and incidents. Ensuring services undertake clinical audit also provides patients and their family / whānau confidence in the quality of the health system.

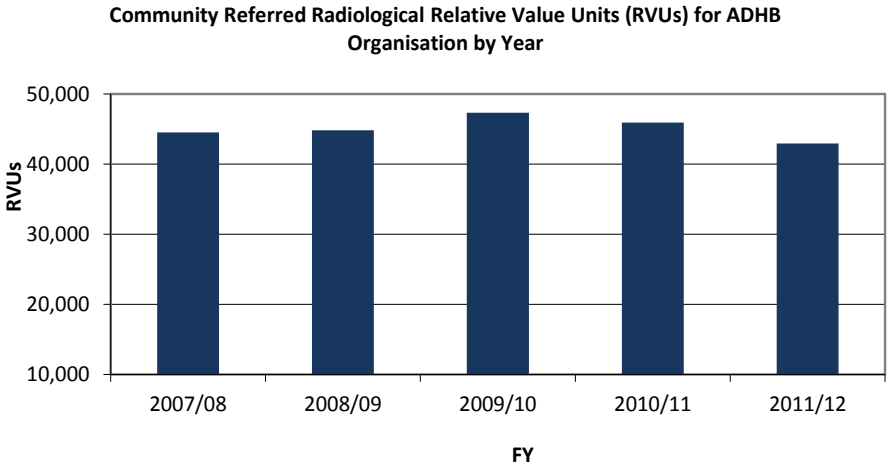
Effective early detection and management of patients reduces demand on more costly secondary and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

Output: Community Referred Testing and Diagnostics

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Purchase and monitor community referred testing and diagnostic services including: • laboratory tests • radiological services for cardiology, neurology, audiology, endocrinology, respiratory, orthopaedics • pacemaker physiology tests • ante-natal screening	Community referred laboratory tests and other diagnostic services	***Quantity*** Number community laboratory tests by provider	The no. of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services	*DML = 342,530*	*346,171*	Demand driven forecast activity	Demand driven forecast activity	Prompt diagnosis of acute and chronic conditions. Patient reassurance in the case of negative results. Reduced demand on specialist outpatient appointments **Impacts measured by** Percentage of women who have birthed in last quarter of year who have had a test for chlamydia in previous three quarters of year *Hospital scans use PU code CS01001
				LTA = 2,581,254 2011/12	*2,875,556*	Demand driven activity	Demand driven activity	
		Number radiological procedures referred by GPs to hospital or to community providers	The no. of community referred radiological procedures is a direct indicator of the total volume of radiology diagnostic services provided for the population	43,460 2011/12 Radiological procedures referred by GPs *to community-based or hospital services**	47,496	Demand driven activity	Demand driven activity	
		Quality Complaints as percentage of total no. of laboratory tests	A high quality community laboratory diagnostic service will receive only a small number of complaints	0.00001% *As at Dec 2012* *data covers the 3 Auckland metro DHBs*		↓		
		Timeliness Average waiting time in minutes for a sample of patients attending Auckland DHB collection centres between 7am and 11am (peak time)	A high quality service will process patients quickly and efficiently, thereby avoiding long waiting times	6.3 mins *14 Jan – 1 Mar 2013*	7.8 mins	< 30 mins	< 30 mins	
		85% of accepted community referrals (accepted by the hospital) for CT and 75% for MRI scans receive their scan within 6 weeks (42 days) by July 2014	Timely access to diagnostic testing makes an important contribution to good patient outcomes	64% As at Feb 2013	56%	CT = 85% MRI = 75%	85%	

Trend graphs for key measures for community referred testing and diagnostics



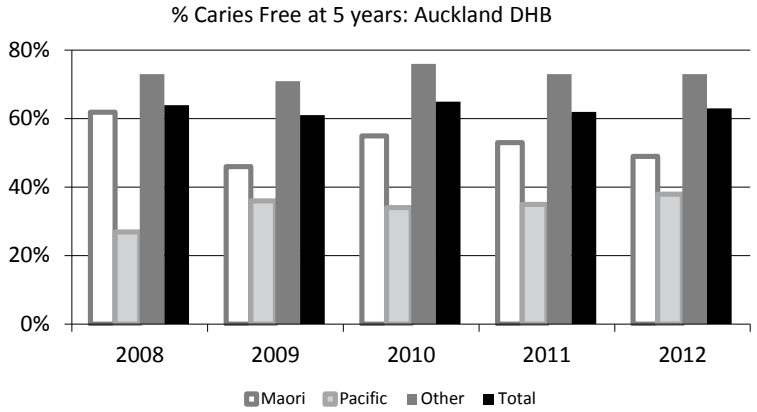


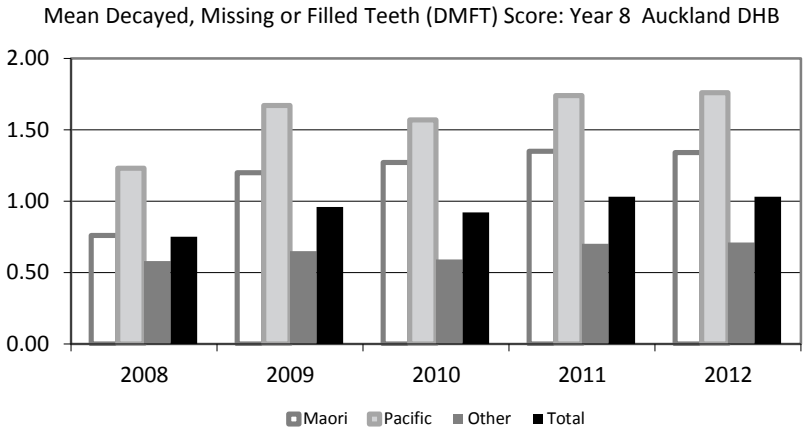
The graph shows the total number of scans performed across community based radiology and hospital. CT and MRI scans are performed by the hospital while CR and Ultrasound may be performed in the community by private radiology providers. GPs may refer to private providers as a way of reducing the number of inappropriate scans done in the hospital setting.

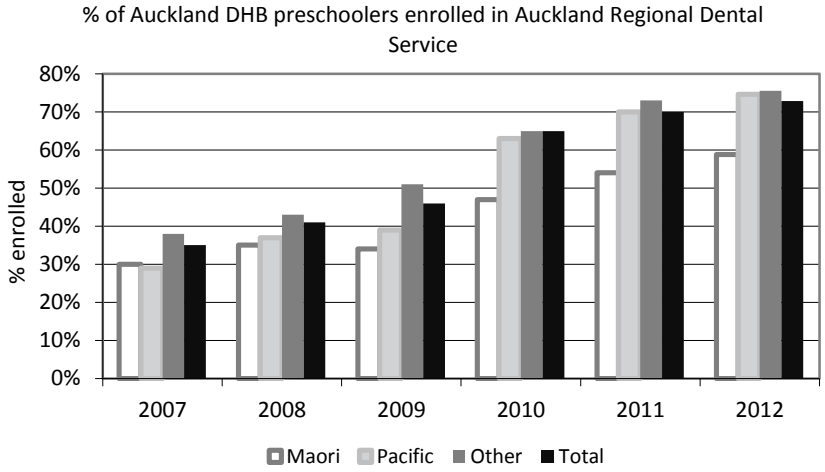
Output: Oral Health

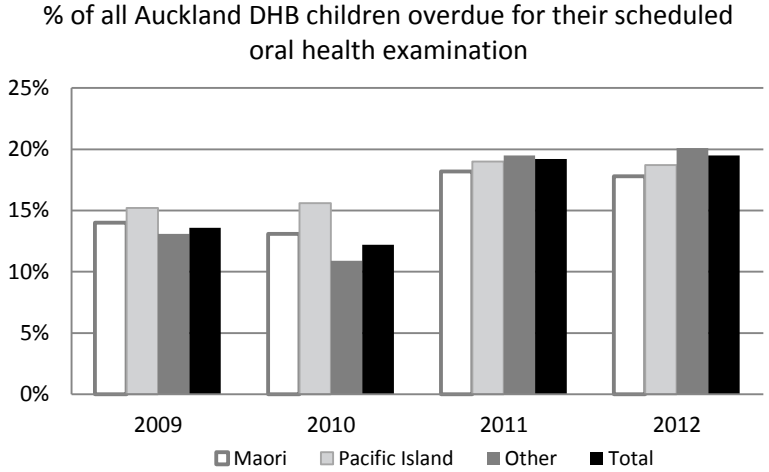
These activities	Deliver these outputs	The outputs are measure by	Measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Fund and/or provide a range of services for the metro Auckland region that promote, improve, maintain and restore good oral health including: • Health promotion activities targeting children and adolescents living in disadvantaged areas. Particularly Māori and Pacific • Oral health examination and oral health education provided to preschool children & their parents • Oral health examination and education provided to school age children and adolescents. • Oral health examination and pain relief provided to low income adults with oral health problems	Oral Health education Oral examinations and treatment among preschool children, school children, and adolescents.	***Quantity*** Enrolment rates in children under five by ethnicity: • Total population	Output is directly related to the proportion of children enrolled in the service	**22,162** (73%) *2012 calendar year*	**28,096** (80%)	**<u>2013</u>** 22,990 (76%) **<u>2014</u>** 80% enrolled	**<u>2013</u>** 32,195 (83%) **<u>2014</u>** 85%	Caries among children and adolescents is prevented, detected early and treated before major damage to teeth occurs Improvement of overall oral health with the reduction of inequalities among different ethnic groups **Impacts measured by** Percentage of children caries free and average Decayed , Missing and Filled Teeth (DMFT) of year 8 children by ethnic group Percentage of children caries free and average decayed , missing and filled teeth of 5-year-old children by ethnic group
		Utilisation rates for adolescents	This is an indication of the volume of service in relation to the target population	81.4% *2011 calendar year*		**<u>2013</u>** 85% **<u>2014</u>** 85%	**<u>2013</u>** 85% **<u>2014</u>** 85%	
		Number of visits of preschool and school children to oral health services (including adolescents)	Provides an indication of the volume of service.	84,246 *2012 calendar year*	112,185 *2011 calendar year*	86,800	115,400a	
		Quality Number of complaints in the financial year	A high quality service will receive low numbers of complaints	8	20	↓	↓	
		Timeliness Arrears rates by ethncity: Total population	A timely oral health service will have low arrears rates	19.2% *2012 calendar year*	13.7%	Overall 2013- 10% 2014- 7%		

Trend graphs for key measures for oral health







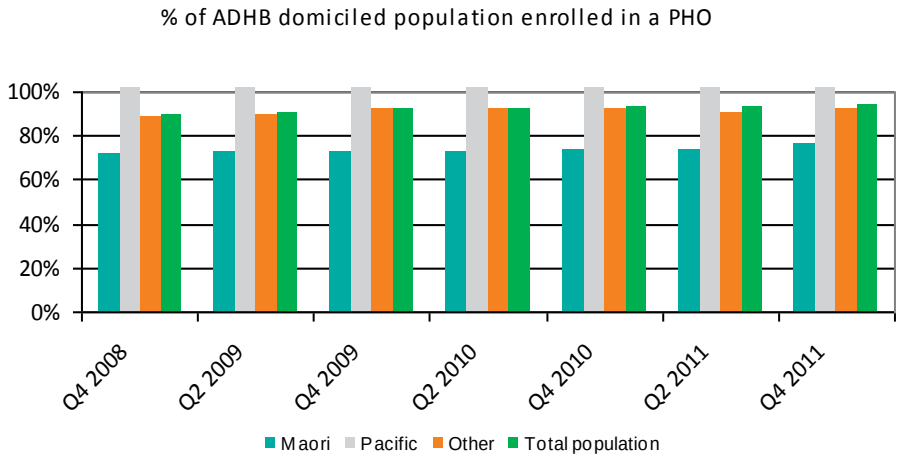


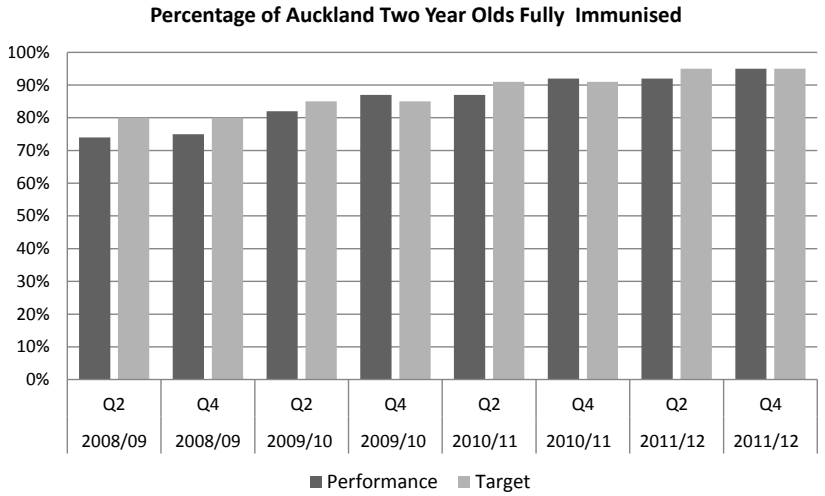
Output: Primary Health Care

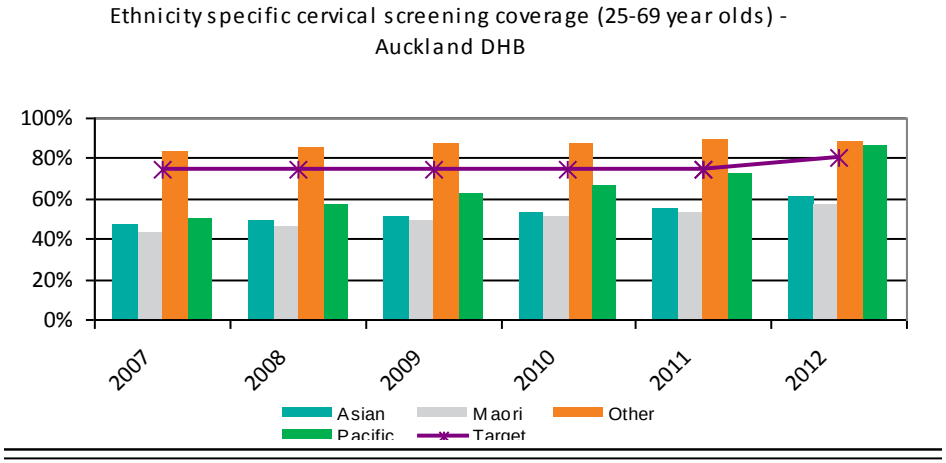
These activities	Deliver these outputs	The outputs are measured by	These measures are chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Subsidise the provision of primary care services provided by GP teams, including certain specific health programmes e.g. CVD Risk assessment and management, immunisation and before schools checks Subsidise the provision of primary care services provided by Primary Health Organisations including diabetes coordination and services to improve access for high risk groups Subsidise Region-wide work to improve the performance of primary care through the GAIHN. Contract cancer care coordination (navigation) services for Māori and Pacific populations	Enrolment in PHO affiliated general practice teams. Primary care nurse and doctor consultations, diagnosis and treatment for acute and long term conditions as well as social support and advice to families, in enrolled populations. Preventive health care including immunisation, before schools checks, and advice and help to quit smoking. Referral to secondary care services when appropriate. [Community referred diagnostic and pharmaceutical outputs included in a separate output subclass]	***Quantity*** Primary care enrolment rates	Primary care enrolment rates give an indication of access to primary care health services.	93% *Q2 2012/13*	95%	95%	95%	Management and cure of treatable conditions. Prevention of illness. Maintenance of functional independence. Pain relief and reassurance. Minimising unnecessary use of high cost secondary care ("gate-keeping") **Impacts measured by** Standardised acute discharge rate and case-weights – trend and benchmarked against other DHBs
		Immunisation health target achievement - 90% of eight month olds fully immunised by July 2014	Preventive health services comprise an important and high impact component of primary care. A high immunisation rate therefore gives an indication of how well our primary care services are providing preventive health care	91% *Q2 2012/13*	92%	90%	90%	
		Cervical screening coverage	As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care	77.5% *3 year coverage as at December 2012*	75.7%	75%	75%	
		Percentage of B4 School Checks completed	Coverage is a standard measure of output from screening programmes	54% *As at Q2 2012/13 (ie. mid year)*	36%	90% (year end target)	80% (year end target)	
		Quality Proportion of practices with cornerstone accreditation	Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. In order to be accredited practices must accurately assess their level of performance in relation to established standards	41% Dec 2012	38%	↑	↑	

These activities	Deliver these outputs	The outputs are measured by	These measures are chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
		Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and in the risk of the individuals contracting smoking related diseases	37% *Q2 2012/13*	38%	90%	90%	
		Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	Ensuring long-term conditions are identified early and managed appropriately, will help improve the health and disability services people receive and aid in the promotion and protection of good health and independence	66.4% *Q2 2012/13*	54.1%	90%	90%	
		Timeliness GMS claims from after-hours providers per 10,000 of population	The utilisation of primary care during weekends provides an indicator of the timeliness of the services available. If availability is low or costs too high then this will be reflected in the utilisation rate	305 per 10,000 *2011/12*	429 per 10,000	Demand driven forecast activity	Demand driven forecast activity	

Trend graphs for key measures for primary health care







Output: Pharmacy

These activities	Deliver these outputs	The outputs are measured by	These measures are chosen because	Baseline		Target 2013-14		Impacts (intermediate outcomes)
				ADHB	WDHB	ADHB	WDHB	
Subsidise the community based provision of prescribed pharmaceuticals.	Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations.	***Quantity*** Total value of subsidy provided.	This indicates the total DHB contribution towards patients' community drug costs	$132,776,975 *2011/12*	$118,001,495	*n/a*	*n/a*	Good access to effective pharmaceutical treatments. Lower per capita out of pocket and total expenditure on pharmaceuticals **Impacts measured by** Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge.
		Number of prescription items subsidised	Indicator of overall volume of community pharmacy subsidy to our population	6,421,850 2011/12	6,532,756	*n/a*	*n/a*	
		Quality Proportion of prescriptions with a valid NHI number	The extent to which community pharmacists are entering NHI numbers during the dispensing process; this links individuals with dispensing activity to improve data integrity in the national pharms warehouse	96% 2011/12	97%	100%	100%	
		Timeliness The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	Represents the accessibility of after-hours pharmacy services to the population	98% As at Mar 2013	94%	95%	90%	

5.3 Output Class 3: Intensive Assessment and Treatment

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

These include:

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

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

Outputs that relate to this class of activity include:

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

Contribution to outcomes

Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality, restores functional independence in the case of elective surgery, and improves the health-related quality of life in older adults, thereby improving population health.

Ensuring good access to **intensive assessment and treatment** for all population groups, and giving consideration to health disparities in the prioritisation of service mix helps to reduce those disparities.

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

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

Output: Acute Services

These activities	Deliver these outputs	The outputs measured are	The measures are chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Provide an emergency and acute care service with the following characteristics: • Timely access to all service components (including diagnostics) and appropriate timely discharge • Capacity to meet needs • Right treatment in the right place • Timely patient transfer to appropriate services from Emergency Department • Good access to support services in the community or primary care level to support patient recovery.	Acute inpatient services Emergency department services	***Quantity*** Number of Emergency Department attendances (child and adult)	An indicator of the volume of emergency care provided to our population	95,659 *2011/12*	103,458	Demand driven forecast activity	Demand driven forecast activity	Effective and prompt resolution of medical and surgical emergencies and acute conditions Reduced mortality Improved patient experience of our services Improved engagement of clinicians and other health professionals Patients less likely to be readmitted **Impacts measured by** Age standardised 30 day survival from acute transmural myocardial infarction (WDHB only)
		Acute WIES total (Auckland DHB Provider)	An indicator of the volume of acute hospital service provided to our population	93,838 *2011/12*	53,327	50,895 for Auckland Population; 41,604 for IDF populations	53,327	
		Quality Readmission rates acute readmissions within 28 days	Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care	10.20% *Dec 2012*	9.6%	10.2%	9%	
		Timeliness Compliance with national health target of 95% of Emergency Department patients discharged admitted or transferred within 6 hours of arrival	Emergency care is urgent by definition, long stays cause overcrowding, negative clinical outcomes and compromised standards of privacy and dignity	95% *Q2 2011/12*	97%	95%	95%	
		Compliance with national health target of all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy	Timely access to cancer treatment for everyone needing it supports public trust in the health and disability system, and that services can be used with confidence	Chemo 100% Radiation 100% *Q2 2012/13*	Chemo 100% Radiation 100%	100%	100%	

Output: Maternity

These activities	deliver these outputs	The outputs are measured by	The measures are chosen because	Baseline		Target 2013-14		That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB	
Provide maternity and neonatal care that is responsive to the needs of women, babies and their families and together with primary care providers deliver care in an integrated, accessible, safe and equitable manner	Lead Maternity Care antenatal care, primary birthing and postnatal care for low risk women Obstetric consultations and intra-partum care for women needing secondary care Obstetric, Maternal Medicine, Foetal Medicine and midwifery antenatal consultations, inpatient, intra-partum and post-partum care for women needing tertiary and quaternary care	***Quantity*** Number of births	An indicator of volume of service provide to our population	7,523 *2010/11*	6,873	Demand driven	Demand driven	Safer childbirth Healthier children **Impacts measured by** APGAR score ≤ 6 at 5 mins for live term infants Blood loss ≥ 1500 ml during first 24 hours following a vaginal birth Blood loss ≥ 1500mls during first 24 hours following caesarean birth Families satisfaction with care
		Number of first obstetric consultations	An indicator of volume of service provide to our population	4,410 *2011 year*	3,269	Demand driven	Demand driven	
		Number of subsequent obstetric consults	An indicator of volume of service provide to our population	4,348 *2011 year*	2,546	Demand driven	Demand driven	
		Proportion of all births delivered by caesarean section	An indicator of volume of service provide to our population	32.5% *2012 year*	28.8%	↓	↓	
		Quality Established exclusive breastfeeding at discharge excluding NICU admissions	A good quality maternity service is 'baby-friendly' and will have high rates of established exclusive breastfeeding by the point of discharge	81% *2011 year*	77.77%	>=80%	75%	
		Third/fourth degree tears for all primiparous vaginal births	Women's Hospital Australasia core indicator: 3rd/4th degree tears major have a significant impact on quality of life	2.2% *2012 year*	3.3%	↓	↓	
		Admission of term babies to NICU	An indicator of intra-partum care	5.4% *2012*	n/a	↓	n/a	
		Timeliness Number of women booking before end of 1st trimester	Early booking and antenatal care is associated with better maternal/baby health outcomes. If our service is timely and accessible, women will book at early gestation	New measure	New measure	↑	↑	

Output: Elective (Inpatient/Outpatient)

These activities	Deliver these outputs	Outputs measured by	These measures chosen because	Baseline		Target 2013-14		That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB	
Provide and purchase elective inpatient and outpatient services	Elective inpatient services Elective outpatient services	***Quantity*** Delivery of health target for elective surgical discharges (Health target)	Elective surgery has a major impact on the health status of New Zealanders by reducing disability (e.g. cataract surgery and arthroplasty) and by reducing mortality (e.g. PCI)	11,981 *2011-12*	15,891	13,499	16,701	Restoration of functional independence Increased life expectancy Improved surgical infection rates Improved waiting times for our services Fewer adverse clinical events Patients less likely to be readmitted **Impacts measured by** Improved surgical Intervention rate (per 10,000 pop)
		Surgical intervention rate (per 10,000 of population)	The need for elective surgery varies according to the population makeup (e.g. people require more elective surgery as they age). By standardising surgical output for our population, we can assess whether our output is high or low compared to the national norm	16.49 (Joints) 32.78 (Cataracts) 5.34 (Cardiac) 12.22 (PCR) 31.15 (Angio) *Year ending Sep 2012*	21.59 36.76 7.75 13.10 40.78	21 27 6.5 11.9 33.9	21 27 6.5 11.9 33.9	
		Number of first specialist assessment (FSA) outpatient consultations	First specialist assessment consultations are important component of our elective services output and the total number is a good indicator of the volume of our output	83,795 *2011/12*	33,612	49,703 for Auckland Population 33,581 for IDF populations	Demand driven forecast activity	
		Quality Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – Health Quality and Safety Commission	Health Quality and Safety Commission defined	*New measure* *No baseline data*	*New measure*	↓	↓	

These activities	Deliver these outputs	Outputs measured by	These measures chosen because	Baseline		Target 2013-14		That will lead to these impacts
				ADHB	WDHB	ADHB	WDHB	
		Post-operative sepsis and DVT/PE rates - Health Quality and Safety Commission	Health Quality and Safety Commission defined	*New measure*	*New measure*	↓	↓	
		Percentage of respondents who rate their care and treatment as very good or excellent	Reflects the quality of the service	84% Feb 2013	*n/a*	90%	*n/a*	
		Timeliness Patients waiting longer than five months for their First Specialist Assessment (FSA)	Long waiting times for first specialist assessment causes people to suffer conditions longer than necessary, and therefore reflects poor timeliness of the services	0.5% *Jan 2013*	0.3%	0%	0%	
		Patients given a commitment to treatment but not treated within five months	If a decision to treat has been made then it can be assumed that the treatment will lead to health gain. The longer a patient waits for this the less benefit s/he will get from the treatment	1.2% *Jan 2013*	0.9%	0%	0%	

Output: Assessment Treatment and Rehabilitation (Inpatient)

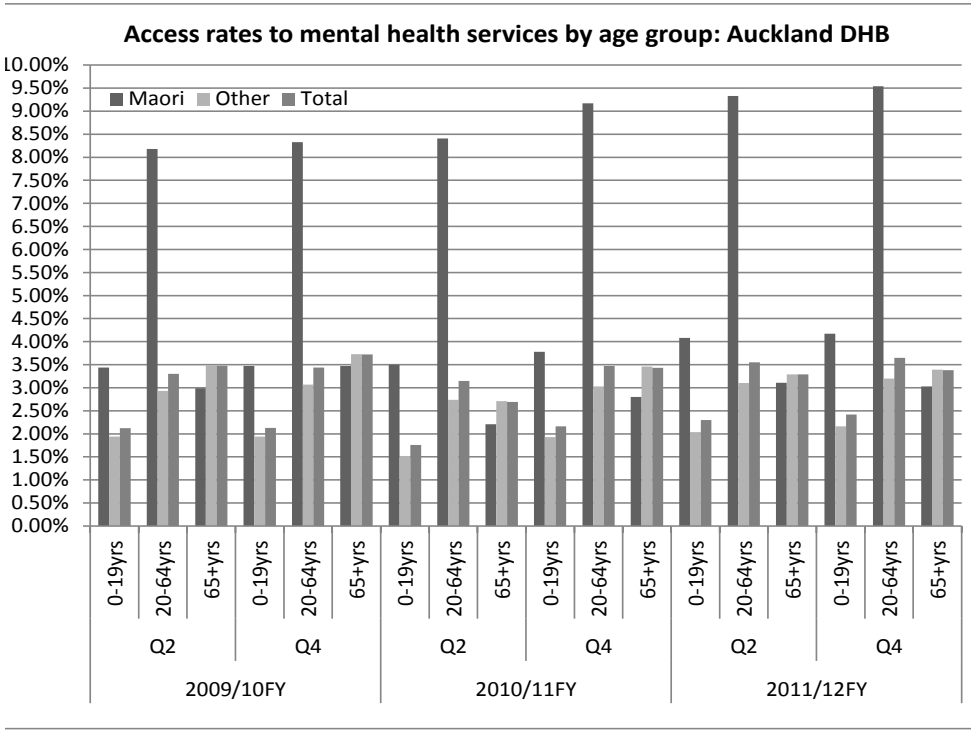
These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults	Sub-acute inpatient care of older adults	***Quantity*** Assessment Treatment and Rehabilitation bed days	Bed-days are a standard measure of the total output from this activity	35,545 *2010-11*	32,178	≥	≥	Maximising functional independence and health-related quality of life in older adults **Impacts measured by** The proportion of patients with an improvement in function between Assessment Treatment and Rehabilitation admission and within 3 days of discharge as measured by the Barthel index
		No. of Assessment Treatment and Rehabilitation inpatient events	A standard measure of the total output from this activity	1,996 *2010-11*	1,826	Demand driven forecast activity	Demand driven forecast activityΩ	
		Quality In-hospital fractured neck of femur (FNOF) per 1000 admissions (age/sex standardised) Health Quality and Safety Commission	A high quality Assessment Treatment and Rehabilitation service will rehabilitate their patients so that they fall less, this would indicate a high quality service	7.6 *average from May 11 – Apr 12*	New measure	↓	↓	
		Timeliness Proportion waiting 4 days or less from waitlist date to admission to Assessment Treatment and Rehabilitation service	This is an indicator of the timeliness of our Assessment Treatment and Rehabilitation (AT&R) service	86% *2012*	52%	≤ 4 days	≤ 4 days	

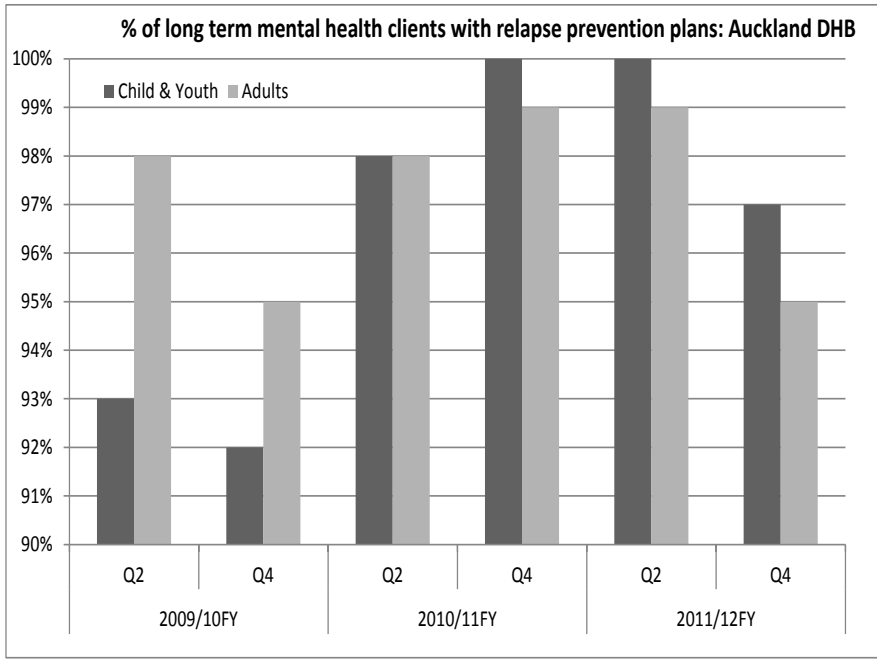
Output: Mental Health

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Age	Eth	Baseline		Target 2013-14		Impacts
						ADHB	WDHB	ADHB	WDHB	
Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adults -Acute & Intensive services -Community based clinical treatment & therapy services -Services to promote resilience, recovery and connectedness.	***Quantity*** Access Rates for total and specific population groups (the proportion of the population using Mental Health and Addiction services in the last year) The population groups are: Total / child & youth / adult / older adult population (all ethnicities) Māori (total / adult / child & youth / older adult)	This indicator demonstrates the utilisation of our mental health services in relation to our population size. Low "Access" rates would indicate that our services may not be reaching a high proportion of those who need them	0-19 20-64 65+	Māori Total Māori Total Total	4.42% 2.60% 10.36% 3.71% 3.52% *At Sept 2012*	3.58% 2.66% 7.66% 3.45% 2.38%	3.0% 3.0% 3.3% 3.3%	3.58% 2.66% 7.66% 3.45%	Prompt recovery from acute mental illness Prevention of mental illness relapses Social integration and improved quality of life **Impact measured by** Percentage of overnight discharges from DHB mental health and addiction services acute inpatient units that result in readmission to an acute inpatient unit within 28 days of discharge
		Quality Proportion of long term clients with Relapse Prevention Plan [target of 95%] in the pop. groups	Relapse prevention programmes targeted to patients with a high risk of relapse/recurrence who have recovered after antidepressant treatment significantly improves antidepressant adherence and depressive symptom outcomes. The absence of a relapse prevention plan among mental health patients therefore indicates a failing in service quality	Adult Child & Youth	Māori Pacific Other Māori Pacific Other	96% 99% 95% 100% 100% 91% *As at January 2013*	95.5% 99.37% 96.63% 100% 100% 92.12%	95% 95% 95% 95% 95% 95%	95% 95% 95% 95% 95% 95%	

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Age	Eth	Baseline		Target 2013-14		Impacts
						ADHB	WDHB	ADHB	WDHB	
		Timeliness Shorter waits for non-urgent mental health and addiction services -Seen within 3 weeks -Seen within 8 weeks	Waiting times for service are an indicator of timeliness. Note: While the national DHB performance measures are 80% and 95%. These are broken down by type of service and by age band			60.8% 76.4% *April 2011 – March 2012*	77.6% 86.2%	80% 95%	80% 95%	

Trend graphs for key measures for mental health





5.4 Output Class 4: Rehabilitation and Support Services

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

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

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

Contribution to outcomes

By helping to restore function and independent living the main contribution of **rehabilitation and support services** to health is in improving health-related quality of life. There is some evidence that this may also improve length of life.

Ensuring that rehabilitation and support services are targeted to those most in need helps to reduce health inequalities.

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

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

Output: Home Based Support

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Assess and plan the needs of older people for Home Based Support Fund home based support services delivered in accordance with assessed needs	Home based support assessments Home based support care	***Quantity*** Total number of InterRAI assessments per month	Simple indicator of output of service	400 per month	n/a	150 per month	n/a	Older people with complex needs remain living in their home for longer Better health and fewer accidents (eg falls) among people over 65 years Improved happiness and quality of life for older adults **Impacts measured by** Proportion of NASC referrals assessed to have high or very high needs who reside in their own home
		Quality The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Good quality, comprehensive and regular assessments will reduce numbers going into residential care and, for older people, services in their own home are much more convenient	84% *calendar year 2012*	38%	95%	65%	
		Timeliness Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service	96% *Av. 2012 calendar year*	88.9%	≥	≥	

Output: Palliative Care

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Contract or provide high quality generalist and specialist palliative care services	Hospice provided palliative care Specialist community palliative care services Home based palliative care services.	***Quantity*** Total number of completed episodes of care (death or discharge)	Inpatient hospice care is the main component of our expenditure on palliative care. Episodes or contacts measure the total output from this activity	911 *2011-12*	n/a	Demand driven	n/a	Improved quality of life for patients with life-threatening illness (and for their families/whānau) **Impacts measured by** Proportion of hospice patient deaths occurring in hospitals versus at home
		Quality Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline)	Indicator of access equality	**Admissions** M 5% P 12% A 11% **Deaths** M 7% P 11% A 8% *Apr 2011-March 2012*	**Admissions** M 6% P 4% **Deaths** M 5% P 3%	% admitted should reflect % deaths by ethnicity	% admitted should reflect % deaths by ethnicity	
		Timeliness Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	Well functioning service should provide timely access for acute patients	11%	18.44%	↓	↓	

Output: Residential Care

These activities	Deliver these outputs	The outputs are measured by	These measures chosen because	Baseline		Target 2013-14		Impacts
				ADHB	WDHB	ADHB	WDHB	
Ensure access to subsidised beds is based on assessed need Ensure sufficient contracted beds are available to people assessed as requiring long term residential care	Residential care bed days	***Quantity*** Total number of subsidised aged residential care bed days	Bed days are a standard measure of the volume of aged residential care service	954,667 *Oct 10 – Sep 2011*	803,220	≥	≥	Safe care with good management of long term conditions and maximised quality of life for those no longer able to live independently in their own home **Impacts measured by** Standardised acute admission rates from residential care
		Quality Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year	Good quality, comprehensive and regular assessments will improve the quality of care received by residents	New measure	20%	20%	TBC	
		Timeliness Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service	96% *Av. Oct/Nov 2011*	TBC	≥	≥	

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MODULE 6: Service Configuration

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

6.1 Service Coverage and Service Change

A provisional list of proposed service changes for implementation in the 2013- 14 year is being developed by the DHB's executive, considering:

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

Type of Service Change	**Area impacted by Service Change**	**Description of Service Change**
New provider/s	Fertility Services	RFP during 2012-13 with potential for a new provider to be in place during 2013-14. Changes will include refinement of the service delivery model and quality framework and a new governance structure to oversee performance of this service
Potential service re-alignment	Planning and Funding services	Waitemata DHB and Auckland DHB planning and funding teams are to merge – this process is likely to produce some internal change and may result in changes to contracting
Level and configuration of services	Overnight services – Auckland and Waitemata DHBs	The Auckland and Waitemata DHBs are currently reviewing the level and configuration of overnight services (10pm-8am) The review also investigates how this service can be delivered in a cost effective manner. One option being considered is to bring the overnight service back in-house to be delivered from the hospital emergency departments. Implementation of the review is likely to start during 2013-14
Review service specifications	Review service specifications associated with contracts with some providers re services to Pacific people	Metro Auckland regional Pacific health needs assessment outcomes framework will inform changes Will potentially impact those services that provide for Pacific • Pregnancy support • First year of life • Asthma

Type of Service Change	Area impacted by Service Change	Description of Service Change
		• Youth at risk • Mobile nurse service
Waiheke Island health service	Health services for Waiheke Island,	Determine current and future provision of health services provided on Waiheke Island, as well as an improved connection to after-hours service The purpose of this process is to improve integration and ensure sustainability of the health services being delivered on Waiheke Island *Nb. There may not be change as a result of this scoping*
Service repatriation	Termination Service	Review of second trimester termination services with a view to repatriate services to DHBs closer to the woman's home
Service review	Gynae-oncology Service	Establish formal gynae-oncology regional network in which Auckland DHB is a sub specialist tertiary provider Review gyne-oncology services as a sub specialist tertiary service and determine capacity to meet regional demands for the service
Service review and collaboration on service delivery	Women's Health Services -	A formal collaboration project is underway between Auckland DHB and Waitemata DHB which links with Counties Manukau DHB The purpose of the collaboration is to review and inform the most appropriate models of care for primary, secondary and tertiary maternity services across the Auckland region Alongside this process, Auckland DHB will also review all primary, secondary and tertiary women's health services to ensure that the models of care and resourcing align with population needs
Implementation of the Community Pharmacy Services Agreement (CPSA)	Pharmacy	Auckland and Waitemata DHBs will continue to support providers and prescribers across the region to implement the new Community Pharmacy Services Agreement
Great Barrier Island	Collaboration on service delivery	Collaboration with local service providers, the community and other agencies to develop and contract for a sustainable funding model with a succession plan for clinical personnel
Regional changes being trialled to improve early access to Alcohol and Other Drugs (AOD) services	Mental health and alcohol and other drug services	As a region we will trial a new configuration of service at one of our AOD providers so that the focus is on working directly with youth in the community where they are. This early intervention approach will improve access to and exit from services Our intention is to reduce the need for 10 of the provider's 19 AOD beds through community management. The resources released will be used to fund the community FTE to work with youth in schools and other youth focussed places. There will be no reduction in service for clients

Type of Service Change	Area impacted by Service Change	Description of Service Change
Regional Service reviews	Mental health and alcohol and other drug services	As part of Regional Service Planning the region is carrying out reviews of the Child and Family Unit and, at the request of the Ministry, a review of both forensic high and complex service users and 'acute' high and complex service users We are also implementing the additional Ministerial funding provided for Perinatal and Maternal Mental health service. Auckland DHB is participating in these reviews and potential service change

MODULE 7: Financial Performance

7.1 Financial Management Overview

Our financial goal is to remain a sustainable and productive organisation for the current and future years.

Given the very constrained Government fiscal position combined with significant cost pressures faced by the public health sector, a deliberate strategy to maintain our financial sustainability is required. We will achieve our financial goal through:

- The prioritisation of our work programmes in order to get the best health and the best health service for the people in our district and region
- A culture of financial accountability and discipline underpinned by a Business Transformation and Performance Improvement programme that seeks to continuously identify and implement improvement initiatives
- Careful planning and implementation of affordable capital developments that enable us to continue meeting the health service delivery requirements for our district
- Implementing smarter ways of delivering quality health services more efficiently, more cost effectively and reducing any waste. We will do this in partnership with our Waitemata DHB colleagues, and also regionally through mechanisms such as healthAlliance, Health Benefits, and nationally through participation in processes such as national contract reviews
- We also commit to deliver government's Budget 2013 initiatives.

Based on year to date financial performance and expectations for the rest of Fiscal Year (FY) 13, supported by an active Business Transformation and Performance Improvement programme and informed by robust organisational and financial analysis:

- We are forecasting an essentially breakeven operating surplus of $0.3m for the FY13 year, against a planned breakeven result. This positive result reflects management of our Inter District Flow growth, containment of cost growth, aided by continued success and progress on the Business Transformation and Performance Improvement programme continuing during the FY13 financial year, with $50.0m savings achieved to date, enabling the DHB to maintain its breakeven record in recent years. For FY13, savings of $67.0m were planned. We expect to achieve the full savings target, including unplanned savings that offset any that are no longer achievable
- Potential risks to this forecast result include the impact of the final Inter District Flow wash-ups, the containment of cost growth in the second half of the year and the continued success of Business Transformation and Performance Improvement programmes. We will proactively manage any identified risks in order to meet the forecast financial result

- In FY13 we will also be required to undertake a full revaluation of Land and Buildings pursuant to a requirement by Audit NZ to bring in further infrastructure assets. This will increase the value of the assets some $38.0m with consequential impacts on depreciation and capital charges of around $3.8m
- Nevertheless, we are planning to continue to return a breakeven result in each of the three planning years. Auckland DHB will continue to drive cost reductions, where feasible, in order to 'live within our means'. This will allow Auckland DHB to generate cash, largely from its depreciation funding, for application to capital projects now considered imperative given the limited capital envelope for the DHB sector (and indeed for most government sectors). This will be required, given the need for extensive investment in facilities and infrastructure in order to meet the long term growth in demand for health services driven by the DHB's population demographics.

Key Assumptions for Financial Projections

Revenue Growth

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

Growth in Population Based Funding Formula revenue for FY14 is based on the National Health Board funding envelope advice, with an increase of $22.464m or 2.49 percent over the FY13 funding envelope (after rebasing adjustments). This includes a 0.89% ($9.294m) increase contribution to cost pressures and 1.6% ($16.679m) for demographic growth.

Growth in Inter District Flow revenue for FY14 is, again, based on the National Health Board funding envelope advice, with an increase of $7.584m or 1.26 percent over the FY13 funding envelope (after rebasing adjustments). This includes a 0.75% ($4.992m) increase contribution to cost pressures and 0.51% ($3.394m) for demographic growth. Relatively minor allowances have also been made for agreed changes in service delivery or production output where appropriate since this advice was received.

As per the guidance from the National Health Board, we have assumed for outer years that the Population Based Funding Formula funding increase will be of the same nominal value as that signalled for FY13 i.e. $21.435m. We have assumed that Inter District Flow revenue will increase by an average of the Population Based Funding Formula increase for our neighbouring regional DHBs or 2.4%. We have assumed no service changes in respect to Inter District Flow revenue.

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

Expenditure Growth

Expenditure growth of $37m or 1.9% above the 2012-13 forecast level is planned. This is driven by demographic growth pressure on services provided by local and regional population growth, cost growth to meet national service objectives, cost growth for employment contracts (including automatic step increases), cost of capital for facility developments and general inflationary pressure on supplies and services.

Key expenditure assumptions include:

- Impact of population growth. Based on the most recent Statistics NZ sub-national population update published in February 2010, demographic projections indicate a 28% increase in the Auckland DHB population and an increase of 464,000 in the Auckland Region over the next 20 years. These same projections also indicate a 96% increase in the proportion of the population aged 65 years and over. We estimate that for FY14 the combined growth of both our own Auckland population and the Inter District Flow population will result in an increase in workload above FY12 in the order of 1.6%
- Impact on Personnel Costs of all settled employment agreements, automatic step increases, Senior Medical Officer job sizing allowances, new funded FTEs, risk provisions for expired employment contracts and of employment agreements expiring during the planning period. We estimate that the impacts of these changes will be in the order of $24.0m or 3.0% over FY13
- FTE numbers for FY 2014 will remain at similar levels to FY 2013. This will be necessary in order to produce the productivity improvements of around 3.3% which will be required in order to offset the cost impacts above and achieve a breakeven result. As a consequence there are some $37.0m of planned savings included on this line
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. We estimate that the price impacts of these changes will be in the order of $5.0m or 1.2% over FY 2013. Costs also reflect the impact of growth in services provided by the DHB. We have includes $12.7m of planned savings on this line. We will work with both Health Benefits Ltd (HBL) and healthAlliance supply chain teams in order to realise these benefits
- Infrastructure costs (not including Interest, Depreciation and Capital Charge) cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. While these have resulted in increases we have been able to contain these costs by reductions to other costs in the same category
- The Business Transformation and Performance Improvement programme is a key tool being used by the DHB to manage cost pressures by identifying savings to ensure the DHB lives within its means. For 2013-14, overall savings of $74.3m are planned. The Business Transformation programme is described in module 3

- Impact of Funder Payment increases (not including Inter District Flow Outflows) including the following major changes
    - Personal Health – Overall Increases Price 0.9% $2.2m and Demographic and Inter District Flow growth 3.7% $15.8m including Rheumatic Fever Programme $1.2m, Community Laboratory Contract $2.5m – Regionally determined, Community Pharmaceuticals $4.0m – per Pharmac proposal, PHO and GMS $5.9m - including Primary Care Initiative $1.0m and register changes during FY 2013 and Additional contracts $4.9m – Inter District Flow Funded
    - Mental Health – Overall Increases Price 0.9% $0.3m and Demographic and access growth 8.3% $1.2m
    - Disability Support (DSS) – Overall Increases Price 0.9% $1.1m and Demographic and access growth 4.2% $5.3m
- Impact of the revaluation of assets on Depreciation and Capital Charge $3.8m
- Impact of Interest rate gains made through the move to Westpac as the preferred supplier of banking services and generally lower market interest rates $1.1m
- Outer Years Expenditure. As the revenue projection for outer years has largely been determine at National Health Board level and there is an expectation that DHBs will continue to breakeven, future expenditure levels have largely been determined. There will be a gap between revenue growth and cost growth. In order to close this gap Auckland DHB will, as previously stated, prioritise its spending and continue to seek efficiencies in order to 'Live with our means'.

Auckland DHB will also deliver on national entity priorities that align with our agreed budget commitments (as outlined in our national priority initiative template).

7.2 Managing the Funding

Auckland DHB receives funding from the Crown and is accountable to the Crown for the governance, management and administration of these funds. Under the New Zealand Public Health and Disability Act, District Health Boards are expected to plan, fund and contract health and disability support services for their population (i.e. eligible people who live in the Auckland DHB area). Auckland DHB has additional obligations to maintain a range of specialist tertiary and quaternary services for the national population.

Overview of the Funding Envelope

For 2013-14, the overall budget across 20 DHBs is approximately $11 billion, a $250m increase over 2012-13. Auckland DHB receives $1,070m (a 2% increase in the Funding Envelope over 2012-13 funding).

	Auckland DHB	Percentage of revenue	Description
Population Based Funding	998m	93%	represents the expected 'minimum' in service/volume growth in order to fully meet population demand
Top slices/National Service funding	$72m	7%	for providing a range of national level services ($53m) and for additional cost items to Auckland DHB: • bad debts ($3m) • primary maternity care ($7m) • land revaluation ($9m)

Auckland DHB is expected to increase hospital, specialist services and NGO/community services, to at least match demographic growth for the year.

Other specific expectations within the Funding Envelope are:

- Aged care subsidies will increase by 0.89% (contribution to cost)
- PHO General Practice first contact payments will increase by 1%
- Elective service targets will increase for Auckland DHB to equal at least the national intervention discharge rates

The Funding Envelope also identifies the projected revenue that Auckland DHB receives from providing services to other DHBs. Similarly, Auckland DHB pays other DHBs for the work they do for our Auckland residents. When including inter-district flows, the total revenue in 2013-14 for Auckland DHB amounts to $1,642m

	$m	% of base
Auckland DHB base appropriation $m	1069.8	
Inter district flow: Inflow	676.1	63.2%
Inter district flow: Outflow	-104.4	-9.8%
Total Auckland DHB revenue	**1641.5**	**153.4%**

The national Inter District Flows forecast is managed through a national and regional process in agreement with DHB CEOs. While the Funding Envelope identifies the Inter District Flow revenue to Auckland DHB, there will be subsequent and ongoing changes to requirements made by other DHBs for their populations. This means that over the 2013-14 year there will be some risk to the actual level of expected revenue from Inter District Flows.

Over the year, there are also adjustments to other items such as devolution of services and other national services, leading to on-going revisions of the Auckland DHB's Funding Envelope amount. Anticipated changes for 2013-14 include:

- Non-devolved Disability Support Services as separate contracts from Ministry of Health– estimated at $11.2m
- Additional electives funding - $26.9m
- Sector Capability and Improvement – a collection of additional funds to support specific areas of previous priority, e.g. immunisations' administration, care plus, etc) - $24.5m

Funding for Auckland DHB is complex because of the multi-layered nature of services that are available and provided within Auckland DHB. As a result, the allocation of funding is also similarly complex and requires considerable effort in balancing the infrastructure cost pressures with population health need across the wide spectrum of the Auckland health care system.

From the Funding Envelope for 2013-14, in comparison to the 2012-13 Funding Envelope, Auckland DHB will receive 1.9% overall increase to $1.831b as 'all in all' funding income. Made up of:

- A Funding Envelope total for the Auckland population of $1,070m, a 2% increase over the Funding Envelope for 2012-13
- Included in the above is $72m for national services
- $681m in Inter District Flows (IDFs) revenue – a 2.0% increase ($14m).
- $80.4m for a series of 'Non-Funding Envelope' related funding for specific contractual service - this sum is what was provided in 2012-13 and, as yet, not been increased.

Ministry of Health Funding for Auckland DHB	**2012/13**	**2013/14**
Pop Based Funding Formula	$ 973,578,481	$ 997,682,346
Top Slice	$ 75,323,453	$ 72,148,794
Funding Envelope	$ 1,048,901,934	$ 1,069,831,140
% Incr on Previous Year	6.3%	2.0%
Funding to Auckland DHB as DOS		
IDF inflow to Auckland City Hospital	$ 435,678,473	$ 445,663,172
IDF inflow to Community/NGO	$ 231,990,141	$ 235,549,504
Total IDF Inflow	$ 667,668,614	$ 681,212,676
% Increase on Previous Year	11.2%	2.0%
Non FE Ministry of Health Monies to Auckland DHB		
DSS Non-devolved	$ 11,189,873	$ 11,189,873
Electives	$ 26,875,902	$ 26,875,902
SCI (Sector capability/careplus)	$ 24,491,061	$ 24,491,061
Eating Disorder Service Contract	$ 4,789,210	$ 4,789,210
Ministry of Health Contracts (eg B4 School Check)	$ 10,492,237	$ 10,492,237
Misc (eg 'caveat income' – ACR)	$ 2,580,000	$ 2,580,000
	$ 80,418,283	$ 80,418,283
Total FE $ for Auckland DHB	$ 1,796,988,831	$ 1,831,462,099
		1.9%

**The reason for the 6.3% increase in 2012-13 from 2011-12 is due to a $29m for national services & $3m for Oral Health business case (last year tranche payment).*

This is a commentary on the Funding Envelope monies for 2013-14 and provides a 'year on year' comparison. Typically the Funding Envelope gets adjusted during the year and this adjustment is reflected in FFARS.

Outflow Payment

From within its funding envelope amount of $1.1b, Auckland DHB is expected to:

- Pay $104m for treatments by other DHBs for Auckland residents.

Auckland DHB Funding for Outflows	2009/10	2010/11	2011/12	2012/13	2013/14
Hospital Inpatients and Maternity	$49,136,567	$49,981,175	$50,757,212	$52,015,335	$54,798,339
Total Health of Older People	$8,843,226	$9,079,718	$8,780,870	$9,129,739	$9,205,593
Total Mental Health	$17,801,309	$17,661,620	$18,171,698	$ 8,156,791	$13,632,528
Total Primary	$23,867,177	$23,745,143	$23,213,274	$31,128,916	$26,807,274
Total Outflows	**$99,648,279**	**$100,467,656**	**$100,923,054**	**$110,430,781**	**$104,443,734**
% Incr on Previous year		0.8%	0.5%	9.4%	(5.4%)

- Have reduced outflow expenditure of $6m because of (i) PHO capitation changes due to boundary alignment; and (ii) top-slice funding to Auckland DHB for Forensic mental Health – so that Auckland DHB will now directly contract with the NGO provider
- Spend $55m on hospital acute and emergency care, as well as electives (e.g. Otahuhu residents will receive a broad range of services at Middlemore Hospital due to its local proximity). Tertiary level Burns and Plastics treatment is provided by Counties Manukau DHB
- Spend approximately $27m on primary medical care and a further $23m on a variety of mental health and older people services.

Actual Available Funding Budget

The available funding 'budget' which can be used to purchase the spectrum of hospital and community services is $1.8b, separated into two components

- For Auckland population = the Population Based Funding, Ministry of Health Contracts and National Services (which is placed within 'Auckland population' for ease of presentation because patient movements are highly variable)
- For Inter District Flow populations = IDF inflow

Funding Budget for 2013-14	$
Auckland DHB Population	$ 1,150,249,423
Inter District Flow	$ 681,212,676
Total	$ 1,831,462,099

The two components require separate sets of conditions to be met in order to allocate the available monies across hospital and community services.

- The 'conditions' for Inter District Flow inflow is relatively straightforward – in that, other DHBs indicate the scope and scale of services that they require and are willing to pay for. In addition, payment arrangements are determined at DHB level (with the national default position if agreement is not reached).
- For Auckland population, the conditions are more complex, taking into account the wider system perspective and varying demand from throughout the system. In this, the hospital sector (Auckland City Hospital and Greenlane Clinical Centre) is one component of the wider consideration.

Principles for 2013-14 allocation

As a start-point, assumptions for allocating funding in 2013-14 are based on meeting known and current health need and population demographics.

Hospital service volumes will be funded for increased volume as a result of the expected population growth based on the expected production level for 2012-13 to those services that are most influenced by demographic change over 2013-14:

- Acute services will be increased at a growth rate to match the forecast population at 2012-13 plus the projected growth over 2013-14. This will need careful stewardship to balance purchasing signals; capacity constraint and service re-design including use of primary care.
- Electives will be funded to maintain the current target levels plus the additional target for 2013-14 (+618 discharges). This level is much higher than that currently being delivered. This is a National Health Board requirement that Auckland DHB achieve the national intervention rate target for surgical procedures.

Non-DRG volume/programmes will be increased at the CCP rate, based on the current year to date actual production level. Further adjustments may be necessary depending on the results of ongoing production planning exercises.

Tertiary Adjuster

Each year Auckland DHB receives a 'Tertiary Adjuster' (TA) payment for the 'tertiariness' of work undertaken at Auckland DHB's hospitals and the consequent added cost.

This recognises that the national reference prices do not necessarily adequately cover the average costs of the more complex work that is undertaken.

The Tertiary Adjuster is a national calculation which is carried by the National Pricing Programme and determines at DRG level the 'extra' costs of treatment and/or diagnosis.

Auckland DHB receives 'two adjuster payments':

- For acute tertiary work with added costs (adults)
- For paediatric tertiary work (Starship)

Tertiary payments are for both Auckland and for Inter District Flow populations and identifiable in the Price Volume Schedule:

Tertiary Adjuster $m	Auckland	Inter District FLow	Total
Adults	3.1	30	33.1
Starship	1.7	16.8	18.5
	4.8	46.8	51.6

Specific additional funding will be for the purchase of service outputs or programmes, wherever capacity is threatened or there is a highly variable volume movement:

- For Oncology Radiotherapy (RT) services, it is proposed to maintain service at current level because of clinical sustainability issues, and Auckland City Hospital has reportedly also experienced a greater proportion of higher complexity patient workload
- For Cardiac services, again, capacity growth is being funded to ensure down-stream activity (such as CVD risk assessment programme also being purchased)
- This means that the above service groups will benefit from a higher share of the new growth funding, requiring larger sacrifices from other Auckland DHB services.

Community and NGO services will be funded only to contract value, or projected utilization if demand driven and legislatively entitled:

- The majority of NGO contracts are demand driven and often driven by referrals from primary/hospital assessments. These are funded to the forecast demographic demand levels
- Community pharmacy is based on the cost of drugs as agreed by the national DHB forum of Chief Executives and Pharmac. The pharmacy mark-up, dispensing fee and co-pay are estimates of recent values per working day, Saturday and Sunday and Public Holidays, paid this year
- Community laboratory expenditure is based on actual contract value
- Ministerial directive for the specific funding of aged residential care at a 1% increase for price, and for PHO general practice contacts a 1% top-up.

Over the past two years, community services have undergone a prioritisation/Value for Money review with a number of contracts being deleted/amended. It is intended that this practice will continue over 2013-14.

7.3 Forecast Financial Statements

The tables below provide a summary of the consolidated financial statements for the audited result for Fiscal Year (FY) 2012, year-end forecasts for FY 2013 and plans for FY 2014 to FY 2016.

Statement of Comprehensive Income

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Government & Crown Agency Sourced	1,152,270	1,212,026	1,231,059	1,255,791	1,281,021
Non-Government & Crown Agency Sourced	78,711	75,061	79,726	76,974	78,712
IDFs & Inter-DHB Sourced	557,876	678,848	691,813	705,648	719,763
TOTAL FUNDING	**1,788,857**	**1,965,936**	**2,002,598**	**2,038,413**	**2,079,495**
Personnel Costs	750,473	757,090	793,771	812,821	829,890
Outsourced Costs	94,198	90,099	71,699	73,421	74,965
Clinical Supplies Costs	224,723	233,414	227,536	232,996	237,890
Infrastructure & Non-Clinical Supplies Costs	173,121	178,161	187,972	180,661	183,469
Payments to Providers	448,336	599,934	617,491	632,354	644,987
IDF Outfows	97,270	106,922	104,044	106,125	108,246
TOTAL EXPENDITURE	**1,788,121**	**1,965,620**	**2,002,513**	**2,038,379**	**2,079,447**
NET SURPLUS/(DEFICIT)	736	316	85	35	48
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	(174)	38,776	-	-	-
TOTAL COMPREHENSIVE INCOME	**562**	**39,092**	**85**	**35**	**48**

Strong financial performance continues to be demonstrated with achievement of a breakeven plan being a key principle for both financial budgeting and financial performance.

The forecast breakeven for FY 2013 and the continuation of these results for the period FY 2013 through to FY 2016 demonstrate the DHB's ability to contain costs in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

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

Statement of Cashflows

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Cashflow from operating activities					
Cash was provided from					
MoH and other Government/Crown	1,832,326	1,895,245	1,922,072	1,961,440	2,000,784
Other Income	77,738	75,312	71,719	68,967	70,705
	1,910,064	1,970,557	1,993,791	2,030,406	2,071,488
Cash was applied to					
Payments for Personnel	(738,999)	(765,058)	(793,775)	(812,821)	(829,890)
Payments for Supplies	(401,389)	(410,337)	(392,525)	(388,698)	(395,584)
Capital Charge Paid	(40,288)	(33,211)	(37,182)	(37,090)	(37,162)
Net GST Paid	(1,201)	(527)	-	-	-
Payments to Providers	(685,492)	(706,856)	(721,535)	(738,479)	(753,233)
	(1,867,369)	(1,915,989)	(1,945,017)	(1,977,088)	(2,015,869)
Net Cash Flow from Operating Activities	42,695	54,568	48,774	53,318	55,619
Investing Activities					
Cash was provided from					
Interest Received	7,779	7,216	8,007	8,007	8,007
Proceeds from Sale of Fixed Assets	19,531		-	-	-
Decrease/(Increase) in Investments	(21,993)	(17,364)	(20,944)	(8,565)	(8,000)
	5,317	(10,148)	(12,937)	(558)	7
Cash was applied to					
Capital Expenditure	(53,825)	(35,184)	(55,325)	(45,000)	(45,000)
Net Cash (Outflow) from Investing Activities	**(48,508)**	**(45,332)**	**(68,262)**	**(45,558)**	**(44,993)**
Financing Activities					
Proceeds from Capital Raised/(Repaid) from the Crown	1,811	1,331	-	-	-
Proceeds from Loans Raised	21,000	384	(108)	(108)	(108)
Interest Paid	(17,806)	(15,875)	(16,340)	(16,340)	(16,340)
Net cash (Outflow) from Financing Activities	**5,005**	**(14,160)**	**(16,448)**	**(16,448)**	**(16,448)**
Net Cash Inflow/(Outflow)	**(808)**	**(4,924)**	**(35,936)**	**(8,688)**	**(5,822)**
Cash & cash equivalents at the start of the year	**90,386**	**89,578**	**84,654**	**48,718**	**40,031**
Cash & cash equivalents at the end of the year	**89,578**	**84,654**	**48,718**	**40,031**	**34,209**

Cashflow forecasts reflect the result of maintaining breakeven operating results. Breakeven operating results give rise to cash surpluses, essentially from the depreciation stream, which can be used to fund the capital projects approved by the Minister of Health (such as the Car Park, Oral Health Project and the Elective Surgery Centre) and other capital projects approved by the Auckland DHB Board.

The main driver of the increase in investments is the transfer IT assets to healthAlliance and our continued investment in IT infrastructure and software via healthAlliance. This is essentially a part of our FY 2014 capital plan totalling $18.4m with the most major component being a $10.0m investment in an IT workspace programme. In addition the investment in Health Benefits will grow from $8.3m in FY 2013 to $11.8m in FY 2014.

Equity injections in FY 2012 and 2013 largely reflect Crown funding for the Oral Health project.

The maintenance of high levels of closing cash forecast for FY 2013 and outer years rise to the opportunity for further strategic investment should the Board choose to do so.

Auckland DHB currently has borrowing facilities with the Ministry of Health of $254.5m, all of which have been drawn. Auckland DHB also has $50.0m in Bonds on issue until September 2015.

Statement of Financial Position

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	89,578	84,654	48,715	40,028	34,206
Trust/special funds	7,901	6,700	6,700	6,700	6,700
Debtors & other receivables	61,821	62,684	63,484	63,484	63,484
Prepayments	1,419	1,589	1,589	1,589	1,589
Inventories	14,117	13,865	13,865	13,865	13,865
	174,837	169,492	134,353	125,666	119,844
NON CURRENT ASSETS					
Trust/special funds	2,129	4,855	4,855	4,855	4,855
Property, Plant and Equipment	842,775	877,688	893,327	894,927	892,689
Intangible Assets	529	316	105	105	105
Derivatives financial instruments	7,467	-	-	-	-
Investment in joint ventures & associates	19,851	35,371	55,055	62,069	70,069
	872,751	918,230	953,342	961,956	967,718
TOTAL ASSETS	**1,047,588**	**1,087,722**	**1,087,695**	**1,087,622**	**1,087,562**
LIABILITIES					
CURRENT LIABILITIES					
Trade and other payables	123,953	131,907	131,907	131,907	131,907
Employee benefits	153,639	144,811	144,807	144,807	144,807
Provisions					
Interest-bearing loans & borrowings	64,527	61,345	61,345	61,345	61,345
Patient & restricted trust funds	1,120	1,130	1,130	1,130	1,130
	343,239	339,193	339,189	339,189	339,189
NON - CURRENT LIABILITIES					
Employee Benefits	21,747	21,938	21,938	21,938	21,938
Interest-bearing loans & borrowings	240,713	244,279	244,171	244,063	243,955
	262,460	266,217	266,109	266,001	265,893
TOTAL LIABILITIES	**605,700**	**605,410**	**605,298**	**605,190**	**605,082**
EQUITY					
Public Equity	574,915	576,247	576,247	576,247	576,247
Accumulated deficit	(483,764)	(483,450)	(483,362)	(483,327)	(483,279)
Other reserves	331,806	370,584	370,584	370,584	370,584
Trust/special funds	18,931	18,931	18,931	18,931	18,931
TOTAL EQUITY	**441,888**	**482,312**	**482,400**	**482,435**	**482,483**
NET ASSETS	**1,047,588**	**1,087,722**	**1,087,698**	**1,087,625**	**1,087,565**

Disposal of Land

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

Statement of Movement in Equity

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Balance at 1 July	**439,516**	**441,889**	**482,311**	**482,396**	**482,431**
Comprehensive Income/(Expense)					
Surplus/Deficit for the Year	736	316	85	35	48
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	(174)	38,776	-	-	-
Total Comprehensive Income	**562**	**39,092**	**85**	**35**	**48**
Owner Transactions					
Capital Contributions from the Crown	1,811	1,330	-	-	-
Balance at 30 June	**441,889**	**482,311**	**482,396**	**482,431**	**482,479**

Asset revaluations as at 30 June 2013 will result in a $38.776m increase in building values, which will in turn increase the equity closing position in FY 2013. Equity injections for the Oral Health project and a modest surpluses forecast for the FY 2014 and outer years improve the equity position.

Additional Information

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

Funding Arm Financial Performance

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Government & Crown Agency Sourced	1,075,141	1,134,433	1,152,148	1,175,191	1,198,695
Non-Government & Crown Agency Sourced	3,147		1,000	-	-
IDFs & Inter-DHB Sourced	543,725	663,248	676,015	689,535	703,326
Total Revenue	**1,622,013**	**1,797,681**	**1,829,163**	**1,864,726**	**1,902,021**
Expenditure					
Payment to Provider	**1,044,519**	1,073,031	1,098,491	1,120,460	1,142,870
Payment to Governance	**6,772**	6,510	5,639	5,752	5,867
	1,051,291	**1,079,541**	**1,104,130**	**1,126,212**	**1,148,737**
NGO Expenditure					
Personal Health	**288,217**	429,865	447,828	455,227	464,267
Mental Health	**29,010**	30,727	30,789	31,550	32,093
DSS	**128,675**	136,273	138,093	141,407	144,377
Public Health	**1,272**	2,140	2,620	2,682	2,739
Maori Health	**939**	929	1,453	1,488	1,513
	448,113	**599,934**	**620,783**	**632,354**	**644,989**
IDF Outfows	**97,493**	106,922	104,045	106,125	108,247
	545,606	**706,856**	**724,828**	**738,479**	**753,236**
Total Expenditure	**1,596,897**	**1,786,397**	**1,828,958**	**1,864,691**	**1,901,973**
Surplus / (Deficit)	**25,116**	**11,284**	**205**	**35**	**48**
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	**25,116**	**11,284**	**205**	**35**	**48**

The Provider has been allocated its Ministry of Health Base funding using National Prices. The DHB's Production Plan provided as part of this planning package summarises the service volumes planned to be delivered by the Provider in 2013-14. As earlier observed, we estimate that for FY 2014 the combined growth of both our own Auckland population and the Inter District Flow population will result in an increase in workload above FY 2012 in the order of 1.6%.

Savings targets of some $10.0m are included in the Funder Arm plan above.

In FY 2012 the Laboratory and ProCare contracts held by Auckland DHB on behalf of Waitemata and Counties Manukau DHBs were deemed to be agency agreements in term of relevant Accounting Standards. On this basis both revenue and expenditure were equally reduced $143m. In FY 2013 a sector-wide review of agency type transactions will be undertaken and clarity sought from the Ministry of Health on how financial reporting will be best reflected in terms of Accounting Standards.

Provider Arm Financial Performance

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Income					
MoH Base via Funder	**1,044,519**	1,073,031	1,098,491	1,120,460	1,142,870
MoH Direct	**50,675**	50,338	51,122	52,145	53,187
Other	**116,082**	117,880	122,313	121,543	124,287
Total Income	**1,211,276**	**1,241,249**	**1,271,926**	**1,294,148**	**1,320,344**
Expenditure					
Personnel	**744,357**	750,405	786,680	805,560	822,477
Outsourced Services	**88,313**	89,188	71,377	73,091	74,625
Clinical Supplies	**224,711**	233,388	227,522	232,983	237,875
Infrastructure & non clinical supplies	**171,577**	170,565	175,925	171,669	174,295
Other	**5,891**	8,721	10,591	10,845	11,072
Total Expenditure	**1,234,849**	**1,252,267**	**1,272,095**	**1,294,148**	**1,320,344**
Surplus / (Deficit)	**(23,573)**	**(11,018)**	**(169)**	-	-
Other Comprehensive Income					
Gains/ (Losses) on Property Revaluations	**(175)**	**38,776**	-	-	-
Total Comprehensive Income	**(23,748)**	**27,758**	**(169)**	-	-

The Provider has been allocated its Ministry of Health base funding using National Prices. The DHB's Production Plan provided as part of this planning package summarises the service volumes planned to be delivered by the Provider in 2013-14. As earlier observed, we estimate that for FY 2014 the combined growth of both our own Auckland Population and the Inter District Flow population will result in an increase in workload above FY 2012 in the order of 1.6%.

Substantial improvements in productivity and cost effectiveness are planned in FY 2014. Savings targets of some $60m are included in the Provider Arm plan above.

Governance and Funding Administration Arm Financial Performance

	Audited $'000	Forecast $'000	Plan $'000	Plan $'000	Plan $'000
Revenue from Funder Arm	**6,772**	6,510	5,639	5,752	5,867
Revenue Other	**86**	37			
	6,858	**6,547**	**5,639**	**5,752**	**5,867**
Expenditure	**7,664**	6,497	5,590	5,752	5,867
Surplus/ (Deficit)	**(806)**	**50**	**49**	-	-
Total Comprehensive Income	**(806)**	**50**	**49**	-	-

The Governance and Funding Administration arm continues to perform within the funding allocated, with a breakeven forecast in FY 2013 and the continuation of breakeven results planned throughout the planning period.

Capital Expenditure

	2011-12 Audited $'000	2012-13 Forecast $'000	2013-14 Plan $'000	2014-15 Plan $'000	2015-16 Plan $'000
Funding Sources:					
Free cashflow from depreciation	**39,694**	39,590	41,157	44,951	47,238
External Funding	**22,809**	-	-	-	-
Cash Reserves	**80,900**	89,578	84,654	48,718	40,031
Total Funding	**143,403**	**129,168**	**125,811**	**93,669**	**87,269**
Baseline Capital Expenditure					
Land	**-**	0	0	0	0
Buildings and Plant	**31,488**	21,257	12,834	14,295	16,351
Clinical Equipment	**19,307**	13,207	41,156	29,194	26,948
Other Equipment	**1,595**	385	985	1,115	1,255
Information Technology	**405**	-	-	-	-
Intangible Assets (Software)	**504**	-	-	-	-
Motor Vehicles	**526**	335	350	396	446
Total Baseline Capital Expenditure	**53,825**	**35,184**	**55,325**	**45,000**	**45,000**
Strategic Investments					
Land	**-**	0	0	0	0
Buildings & Plant	**-**	0	0	0	0
Clinical Equipment	**-**	0	0	0	0
Information Technology	**-**	0	0	0	0
Intangible Assets (Software)	**-**	0	0	0	0
Total Strategic Capital Expenditure	**-**	**-**	**-**	**-**	**-**
Total Capital Payments	**53,825**	**35,184**	**55,325**	**45,000**	**45,000**

The major components of FY14 Baseline Capital Expenditure planned are the Starship Theatre upgrade $9.0m, three separate developments at Lab Plus, Level 4 $9.0m, Clinical fleet replacements $9.4m and Building Seismic strengthening $2.5m. The balance is allocated for high priority clinical items and building works $13.0m.

While there are no Strategic Investment plans approved, we are currently developing business cases for National Capital Investment Committee consideration for the Starship rebuild.

In addition to the Capital Expenditure outlined above, Auckland DHB will continue to invest in IT infrastructure and software via its investment in healthAlliance. This is essentially a part of our FY 2014 capital plan totalling $18.7m with the most major component being a $10m investment in an IT workspace programme.

Banking Facilities and Covenants

Term Debt Facilities

Auckland DHB has term debt facilities of $254.5m with the Ministry of Health which are fully drawn and a public Bond issue of $50.0m, repayable in September 2015.

Shared Commercial Banking Services

Health Benefits Limited undertook a project on behalf of all DHBs to identify a preferred commercial banking services provider for the DHB sector. Westpac was the preferred supplier of banking services from the Request for Proposal process. All DHBs have accepted Westpac as the banking services provider for the sector. DHBs are no longer required to maintain separate stand-by facilities for working capital. The new arrangements are expected to generate savings of over $4m for the sector.

The working capital facilities have been cancelled as they will no longer be required under the shared commercial banking arrangements.

Banking Covenants

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

7.4 Statement of Accounting Policies

The following is a summarised description of the accounting policies used in the preparation of this Annual Plan. A full description of accounting policies used by Auckland DHB for financial reporting, budgeting and forecasting can be found in the 2012 Annual Report on the website at www.adhb.govt.nz/publications.

Reporting entity

The reporting entity is the Auckland District Health Board (Auckland DHB) 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. The consolidated financial statements include Auckland DHB and its subsidiaries and interest in associates and jointly controlled entities.

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 IFRS 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 these 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 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 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: Northern Regional Training Hub (33% owned) and Northern DHB Support Agency Limited (33% owned). The NSDA is now named the Northern Regional Alliance.

Northern Regional Training Hub is an associate 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.

The Northern Regional Alliance (previously the Northern DHB Support Agency Limited) is an associate with Counties-Manukau and Waitemata DHB which 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 (20% owned) 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.

NZ Health Innovation Hub Management Limited (25% owned) works with three other DHBs (Waitemata, Counties-Manukau and Canterbury) to engage with clinicians and industry to collaboratively realise and commercialise products and services that can make a material impact on healthcare in NZ and internationally.

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 District 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
- Work in progress

Owned assets

Except for land and buildings, items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. The latest revaluation was done on 30 June 2011. Additions to property, plant and equipment 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.

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.

Cash and cash equivalents

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

Assets held for sale

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

Impairment of financial assets

Financial assets are assessed for objective evidence of impairment at each balance date. 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. This is covered 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.

Lease 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.

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.

MODULE 8: Performance Measures

8.1 Monitoring Framework Performance Measures

Policy Priorities Dimension						
Performance Measure and Description			**2013/14 Target**		**National Target**	**Frequency**
PP1 Workforce – improving clinical leadership Report progress of DHB work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs			No quantitative target. Qualitative deliverable required		Complete NHB template	*Annual (Q4)*
PP6 Improving the health status of people with severe mental illness through improved access (The average number of people living in our DHB, seen by services per year, rolling every 3 months. Denominator: Projected population of ADHB by age and ethnicity)	Age 0-19	Māori	3.0%		NA	*6 monthly (Q2 and 4)*
		Total	3.0%			
	Age 20-64	Māori	8.18%			
		Total	3.3%			
	Age 65+	Total	3.58%			
PP7 Improving mental health services using relapse prevention planning		Adult (20+)	95%		95%	*6 monthly (Q2 and 4)*
		Children and Youth	95%		95%	
PP8 Shorter waits for non-urgent mental health and addiction services			MH	AOD	Within 3 years **80%** of people referred for non-urgent mental health or addiction services are seen within 3 weeks & **95%** of people are seen within 8 weeks	*Six-Monthly*
	0-19 years	3 weeks	80%	80%		
		8 weeks	95%	95%		
	20-64 years	3 weeks	80%	80%		
		8 weeks	95%	95%		
	65+ years	3 weeks	80%	80%		
		8 weeks	95%	95%		
	Total	3 weeks	80%	80%		
		8 weeks	95%	95%		
PP10 Oral Health DMFT Score at year 8			year 1: 0.90 year 2: 0.85		NA	*Annual*
PP11 Children caries free at 5 years of age			year 1: 68% year 2: 69%		NA	*Annual*
PP12 Utilisation of DHB funded dental services by adolescents (School Year 9 up to and including age 17 years)			Year 1: 85% Year 2: 85%		85%	*Annual*
PP13 Improving the number of children enrolled in DHB funded dental services					NA	*Annual*
Children Enrolled 0-4 years			Year 1: 76% Year 2: 80%			
Children not examined 0-12 years			Year 1: 10% Year 2: 7%			
PP18 Improving community support to maintain the independence of older people The percentage of older people receiving long-term home-support services who have a Comprehensive Clinical Assessment and an individual care plan ** note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term*			95%		95%+	*Quarterly*

Policy Priorities Dimension				
Performance Measure and Description		**2013/14 Target**	**National Target**	**Frequency**
PP20 Improved management for long term conditions (CVD, diabetes and stroke)				
Focus area 1: Cardiovascular disease	>70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	>70%	70%	*Quarterly*
	>95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	>95%	80%	*Quarterly*
Focus area 2: Stroke services	6 percent of potentially eligible stroke patients thrombolysed	6%	6%	*Quarterly*
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%	80%	Annual
Focus area 3: Diabetes Management (HbA1c)	Percentage of enrolled people aged 15-74 with diabetes in the PHO and the most recent HbA1c during the past 12 months of equal to or less than 64 mmol/mol	Maintain or improve appropriate current rate	Maintain or improve appropriate current rate	*Quarterly*
Focus area 3: Diabetes Management (Microalbuminuria and on an ACEi or ARB)	Percentage of of enrolled people aged 45-74 in the PHO with diabetes and microalbuminuria, who are prescribed an ACEI or ARB	Maintain or improve appropriate current rate	Not applicable	Quarterly
PP21 Immunisation coverage	95 per cent of two year olds are fully immunised	95%	95%	*Quarterly*
PP22 Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan			*Quarterly*
PP23 Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan			*Quarterly*
PP24 Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan			*Quarterly*
PP25 Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered			*Quarters 1 and 2*
PP26 The Mental Health and Addiction Service Development Plan	Provide gaps analysis and report against the Service Development Plan milestones			Quarters 1, 2 and 4
PP27 Delivery of the children's action plan	Definitions to be confirmed			Quarterly
PP28 Reducing Rheumatic fever	Provide a progress report against the DHB rheumatic fever prevention plan			*Six monthly (one quarter in arrears)*
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 10% lower than the average over the last 3 years	Achieve a 10% reduction on the Auckland DHB current rate of 3.5:100,000 to 3.2 per 100,000 population		

System Integration Dimension				
Performance Measure and Description		**2013/14 Target**	**National Target**	**Frequency**
SI1 Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	Remain below 95%	Remain below 95% 103% (lower by 3-5.9% from 109%) Remain below 95%	*6 monthly*
	Age 45-64	103% (lower by 3-5.9% from 109%)		
	Age 0-74	Remain below 95%		
SI2 Delivery of Regional Service Plans	A single progress report on behalf of the region agreed by all DHBs within that region			*Quarterly*
SI3 Ensuring delivery of Service coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage			*6 monthly*
SI4 Elective services standardised intervention rates	Major joint replacement procedures	21 per 10,000	21.0 per 10,000	*Annually*
	Cataract Procedures	27 per 10,000	27.0 per 10,000	*Annually*
	Cardiac surgery (a target intervention rate 6.5 per 10,000 of population) If previous rate of 6.5 per 10,000 or above -maintain this rate	6.5 per 10,000	6.5	*Quarterly*
	Percutaneous revascularization (a target rate of at least 11.9 per 10,000 of population)	11.9 per 10,000	11.9	
	Coronary angiography services (a target rate of at least 32.3 per 10,000 of population)	33.9 per 10,000	33.9	
SI5 Delivery of Whānau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers			*Annually*

Ownership Dimension				
Performance Measure and Description		**2013/14 Target**	**National Target**	**Frequency**
OS3 inpatient length of stay	Elective LOS	3.21	3.21	*Quarterly*
	Acute LOS	Maintain or reduce average	4.77	
OS8 Reducing acute readmissions to hospital		Over 75 years: 12.3% All ages: At or below 10.2%	Target set with reference to existing baselines	*Quarterly*
OS10 Improving the quality of data submitted to national collections				
National Health Index (NHI) duplications		Greater than 3.00% and less than or equal to 6.00%	Greater than 3.00% and less than or equal to 6.00%	*Quarterly*
Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI		Greater than 0.50% and less than or equal to 2%	Greater than 0.50% and less than or equal to 2%	
Standard versus edited code descriptors in the NHI		Greater than or equal to 75.00% and less than 90.00%	Greater than or equal to 75.00% and less than 90.00%	
Timeliness of NMDS data		Greater than 2.00% and less than or equal to 5.00% late	Greater than 2.00% and less than or equal to 5.00% late	

Ownership Dimension			
Performance Measure and Description	**2013/14 Target**	**National Target**	**Frequency**
NNPAC Emergency Department admitted events	Greater than or equal to 97.00% and less than 99.50%	Greater than or equal to 97.00% and less than 99.50%	
PRIMHD File Success Rate	Greater than or equal to 98.0% and less than 99.5%	Greater than or equal to 98.0% and less than 99.5%	

Output Dimension			
Performance Measure and Description	**2013/14 Target**	**National Target**	**Frequency**
OP1 Mental health output delivery against Plan Each DHB must monitor, evaluate and report on the delivery of Mental Health Services set out in its Annual Plan Production Plan	Within 5% variance to Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) 5% variance (+/-) of planned volumes for services measured by FTE b) 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	*Quarterly*
Performance Dimension			
Performance Measure and Description	**2013/14 Target**	**National Target**	**Frequency**
DV1 Faster Cancer Treatment Patients referred urgently with a high suspicion of cancer have their first specialist assessment within 14 days Patients with a confirmed diagnosis of cancer receive their first cancer treatment (or other management) within 31 days of decision-to-treat Patients referred urgently with a high suspicion of cancer receive their first cancer treatment (or other management) within 62 days.	100% 100% 100%	100% 100% 100%	*Quarterly template submission*
DV2 Improving waiting times for diagnostic services Accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Accepted referrals for CT scans will receive their scan within 6 weeks (42 days) Accepted referrals for MRI scans will receive their scan within 6 weeks (42 days) People accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 days) People accepted for a diagnostic colonoscopy will receive their procedure within 6 weeks (42 days) Surveillance colonoscopy People waiting for a surveillance or follow-up	85% 85% 75% 50% 50%	85% 85% 75% 50% 50%	*Monthly (using the reporting templates)*

Output Dimension			
Performance Measure and Description	**2013/14 Target**	**National Target**	**Frequency**
colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	50%	50%	
DV3 Measures of acute demand *This measure is a placeholder for measures that may be developed as part of the PHO Performance and Incentive Framework: (e.g. reducing acute admissions/ED presentations)*			

MODULE 9: Appendices

Appendix 1: DHB Board and Management

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

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

Auckland District Health Board is organised into Integrated Healthcare Service Groups, each one led by a Clinical Director. These concentrate the effort of the organisation on our priority areas:

Senior leadership team for Auckland DHB	Ailsa Claire	Chief Executive
	Dr Margaret Wilsher	Chief Medical Officer
	Margaret Dotchin	Chief Nursing Officer
	Sue Waters	Chief Health Professions Officer
	Naida Glavish	Chief Advisor Tikanga (across ADHB and WDHB)
	Dr Denis Jury	Chief Planning and Funding Officer
	Rosalie Percival	Chief Financial Officer
	Vivienne Rawlings	Chief Human Resources Officer
	Linda Wakeling	Chief of Intelligence and Informatics
	Fionnagh Dougan	Interim Director Provider Services
	Greg Balla	Director Provider Business Management
	To be appointed	Director Strategy, Participation and Innovation
	To be appointed	General Manager, Pacific Health
Children's Healthcare Service Group	Dr Richard Aickin	Director
	Sarah Little	Nurse Director
	Fionnagh Dougan	General Manager, Starship
Mental Health and Addictions Healthcare Service Group	Dr Clive Bensemann	Director
	Anna Schofield	Nurse Director
	Helen Wood	General Manager (across ADHB and WDHB)
Adult Healthcare Service Group	Dr Barry Snow	Director
	Dr Ian Civil	Director of Surgery
	Jane Lees	Interim Nurse Director
	Andrew Davies	Performance Director
Cardiovascular Healthcare Service Group	Dr Peter Ruygrok	Director
	Peter Lowry	Interim General Manager
Women's Healthcare Service Group	Maggie O'Brien	Midwifery Director
	Sue Flemming	Director
	Karin Drummond	General Manager
Cancer and Blood Healthcare Service Group	Dr Richard Sullivan	Director
	Jane Lees	Interim Nurse Director
	Peter Lowry	Interim General Manager
Perioperative Services Operations and Clinical Support	Dr Vanessa Beavis	Director
	Ngaire Buchanan	General Manager

Appendix 2: The Production Plan (Price Volume Schedule)

2013-2014 planned outputs for Auckland DHB hospital and specialist service

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult -Surgical	General Surgery	Attendance	12,322	3,099	
		Contact	674	979	
		Cost weighted discharge	8,943	2,729	
		Written plan of care	296	7	
	Liver Transplants	Assessment			80
		Attendance	495	908	
		Procedure			51
		Programme			102,307
	Neurosurgery	Attendance	571	1,782	
		Cost weighted discharge	1,564	4,485	
		Written plan of care	30	117	
	Ophthalmology	Attendance	24,199	33,069	
		Contact	1,400	2,236	
		Cost weighted discharge	1,544	2,385	
		Procedure	2,450	2,889	
		Written plan of care		2	
	Oral Health	Attendance	4,970	11,406	
		Competed treatment	3,887	7,538	
		Cost weighted discharge	265	736	
		Fitting of a Prosthetic eye	32	76	
		Programme	216,000		
		Treatment	1,000	1,726	
	ORL	Attendance	7,775	3,001	
		Contact	1,063	1,478	
		Cost weighted discharge	1,323	1,478	
		Written plan of care	46	1	
	Orthopaedics	Attendance	10,352	1,838	
		Bed Days	5,400		
		Cost weighted discharge	8,876	1,044	
		Service	81,970		
	Orthotics	Service	143,289	99,917	
	Renal Transplant	Attendance	79	264	
		Cost weighted discharge	219	599	
	The Auckland Regional Pain Service	Attendance	1,073	363	
		Client	70	7	
		Contact	421	64	
	Urology	Attendance	4,285	1,382	
		Cost weighted discharge	1,462	2,197	
		Procedure	119	187	
		Written plan of care	475	32	
Adult -Medical	A Plus Links	Assessments	1,688		
		Attendance	2,423		
		Client	2,946		
		Contact	112,845	1,252	
		Hour	10,050		

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult – Medical (Cont)		Occupied bed day	29,793	17	
		Programme	196,424		
		Visit	3,292		
	Critical Care	Service	131,386		
	Dermatology	Attendance	4,146	493	
		Cost weighted discharge	164	46	
		Treatment	3,210	989	
	Diabetes	Attendance	8,715	572	
		Client	3,383	63	
		Contact	4,030	204	
		Procedure	7,000	338	
		Service	10		
	Emergency Medicine	Attendance	650		
		Cost weighted discharge	2,305	557	
		ED Attendance	25,230	6,226	
	Endocrinology	Attendance	3,274	1,776	
		Cost weighted discharge	96	45	
		Test	1,520	291	
	Gastroenterology	Attendance	8,077	722	
		Cost weighted discharge	747	80	
		Procedure	88	22	
		Test	48	19	
	General Medicine	Attendance	1,188	56	
		Cost weighted discharge	9,871	371	
	Immunology	Attendance	1,640	3,510	
		Contact	100	80	
		Cost weighted discharge	207	301	
		Written plan of care	12		
	Infectious Diseases	Attendance	1,458	813	
		Cost weighted discharge	241	72	
		Service	120,178	402,091	
		Written plan of care	66	57	
	Needs Assessment, Service Coordination	Assessment	3,580		
		Hour	4,840		
		Programme	1,169,600		
	Neurology	Attendance	3,031	5,523	
		Cost weighted discharge	1,129	622	
		Programme	180,720		
		Test	85	1,250	
		Written plan of care	368	729	
	ORL	Test	17	4	
	Rehab Plus	Attendance	3,594		
		Day Attendance	812		
		Occupied bed day	8,120	87	
		Visit	3,537		
	Renal Medicine	Attendance	36,976	3,785	
		Cost weighted discharge	1,325	457	
		New client	45	3	
		Patient	1,060	9	
		Service	108,634	45,293	
		Written plan of care	22	4	
	Respiratory Medicine	Adjuster	61,623	100,006	
		Assessment			39

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Adult – Medical (Cont)		Attendance	5,526	2,881	
		Client	1,368	1,928	
		Contact	1,281	50	
		Cost weighted discharge	1,701	925	
		Procedures	127	130	
		Programme			11
		Test	544	317	
	Rheumatology	Attendance	4,180	141	
		Cost weighted discharge	86	39	
	Sexual Health	Contact	9,030	13,355	
		Service	777,639	1,351,287	
Cancer	Haematology	Attendance	11,131	6,030	
		Cost weighted discharge	1,087	1,722	
		Programme	1,992,815	1,779,308	
		Written plan of care	216	22	
	Oncology	Attendance	23,932	76,644	
		Cost weighted discharge	1,158	2,269	
		Programme	3,128,651	6,477,007	
	Palliative Care	Programme	452,565		
Cardiac	Cardiology	Attendance	6,190	818	
		Client	605	2	
		Cost weighted discharge	3,997	4,697	
		Locally Defined	289,752		
		Programme	150,357		15
		Test	2,678	580	
		Written plan of care	161	422	
	Cardiothoracic	Attendance	110	540	
		Cost weighted discharge	2,833	9,464	
	Vascular Surgery	Attendance	1,540	2,438	
		Cost weighted discharge	1,238	2,671	
Children's	Adult Congenital Heart	Attendance			802
		Cost weighted discharge			355
		Programme			48,000
	Audiology	Test	4,910	3,250	
	Child Health & Disability	Adjuster	140,032		
		Client	304,234		
		Contact	1,765		
		Programme	656,217		
		Service	353,817		
		Test	546,130		
	General Paediatrics	Attendance	11,044	359	
		Cost weighted discharge	1,487	1,683	
		Programme	1,536		
	Newborn Services	Attendance	445		
		Cost weighted discharge	1,747	1,828	
		Service	319,285		
	Paediatric Cardiac	Attendance			3,337
		Cost weighted discharge			4,359
		Procedure			190,041
		Programme			40,000
		Written plan of care			755
	Paediatric Dermatology	Attendance	391	496	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
Children's Cont.	Paediatric Developmental Neurology	Attendance	992	81	
	Paediatric Emergency department	Cost weighted discharge	944	621	
		Emergency Department Attendance	11,747	5,580	
	Paediatric Endocrinology	Attendance	917	2,410	
		Client	104	604	
		Cost weighted discharge	49	104	
		Service	9		
	Paediatric Family Information Service	Service	63,000	165,314	
	Paediatric Family Options	Service	83,000	278,366	
	Paediatric Gastroenterology	Attendance	226	804	
		Cost weighted discharge	72	585	
	Paediatric Haem/Onc	Attendance	1,485	7,465	
		Cost weighted discharge	322	1,660	
		Programme	290,486	1,924,658	
	Paediatric Home Health Care	Service	25,409	12,933	
	Paediatric Immunology	Attendance	341	691	
		Cost weighted discharge	34	95	
	Paediatric Infectious Diseases	Attendance	178	358	
		Cost weighted discharge	3	102	
	Paediatric Metabolic	Attendance			1,591
		Contact			949
		Cost weighted discharge	6	54	
		Event			182
	Paediatric Neurology	Attendance	500	1,274	
		Cost weighted discharge	120	506	
		Written plan of care		73	
	Paediatric Neurosurgery	Attendance	88	456	
		Cost weighted discharge	134	979	
		Written plan of care		16	
	Paediatric ORL	Attendance	4,166	1,810	
		Cost weighted discharge	731	1,023	
	Paediatric Orthopaedics	Assessment	11	41	
		Attendance	3,658	5,972	
		Cost weighted discharge	1,031	2,528	
	Paediatric Pain Service	Attendance	60	225	
	Paediatric Palliative Care	Attendance	124,071	277,121	
	Paediatric Renal Medicine	Attendance	293	722	
		Cost weighted discharge	26	318	
		New client		4	
		Patient	18	82	
	Paediatric Respiratory Medicine	Attendance	333	1,100	
		Client	14	218	
		Cost weighted discharge	173	700	
	Paediatric Rheumatology	Attendance	135	553	
		Cost weighted discharge	23	76	

			Proposed Volumes		
Healthcare Service group	**Hospital Specialist Service**	**Unit of Measure**	**Auckland Population**	**Other Populations**	**National Service**
	Paediatric Surgery	Attendance	1,241	3,448	
		Contact		580	
		Cost weighted discharge	859	2,965	
	Whakaruruhau	Service	416,484	853,307	
Operations & Clinical Support	Adult Allied Health	Contact	7,199	2,335	
	ARPHS Management	Programme	1,528,113		
	Clinical Infectious Diseases	Test	1,265	989	
	Elective Services	ADHB Defined	227,307		
		Service	330,712		
	Emergency Management Service	Programme	367,118		
	Imaging	Attendance	76	179	
		Relative Value Unit	32,338	12,242	
	Labs	Service	4,334,138	9,751,449	
	Maori Health Corp	Service	535,729		
	Nutrition	Contact	5,845	5,148	
	Pacific Health Corp	Service	384,375		
	Women's & Child Allied Health	Contact	3,568	4,578	
Women's	Fertility Plus	Attendance	212	293	
		Client	34	47	
		Prescription	33,749	83,192	
		Procedure	373	710	
		Service	31	93	
	Genetics	Attendance			2,538
		Event			356
		Written plan of care			69
	Gynaecology	Attendance	9,954	2,762	
		Cost weighted discharge	2,552	869	
		Procedure	1,657	3,632	
		Written plan of care	2,612	297	
	Obstetrics	Attendance	10,311	6,698	
		Client	330	756	
		Contact	20,957	4,255	
		Cost weighted discharge	5,492	2,741	
		Written plan of care		34	