2014/15

Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Auckland District Health Board

Mihimihi

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

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

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

The Auckland District Health Board Annual Plan for 2014/15 is signed for and on behalf of:

Auckland District Health Board

Dr Lester Levy
Chair
Date

Dr Lee Mathias
Deputy Chair
Date

Our Te Tiriti o Waitangi partners
Te Runanga o Ngati Whatua

ONZM JP

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

And signed on behalf of

The Crown

31.3.15.

Hon Dr Jonathan Coleman
Minister of Health
Date

Hon Bill English
Minister of Finance
Date 7/4/15

Office of Hon Dr Jonathan Coleman

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

13 APR 2015

Dr Lester Levy
Chair
Auckland District Health Board
Private Bag 92189
Victoria Street West
Auckland 1142

Dear Dr Levy

Auckland District Health Board 2014/15 Annual Plan

This letter is to advise you that together with the Minister of Finance I have approved and signed Auckland District Health Board's (DHB's) 2014/15 Annual Plan for one year.

I wish to emphasise how important annual plans are for ensuring appropriate accountability arrangements are in place. I appreciate the significant work that goes into preparing your Annual Plan and thank you for your effort.

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 2014, Vote Health again received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

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 DHBs' operation and service delivery. Improvements through national, regional and sub-regional initiatives should continue to be a key focus for all DHBs.

I understand that your DHB is planning a breakeven for 2014/15 and the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2014/15.

Better Public Services (BPS): Results for New Zealanders
Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

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

National Health Targets
Your Annual Plan generally includes a good range of actions that will lead to improved or continued performance against the health targets. As you are aware, there is one new addition to the target set for 2014/15. From quarter two, the 62 day Faster Cancer treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016.

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Although Auckland DHB is performing well in most health target areas, in the year ahead, I am asking all DHBs to particularly focus on ensuring appropriate actions are implemented to support immunisation service delivery.

Care Closer to Home
I am pleased to see tangible actions in your Annual Plan that demonstrate how you will broaden the scope of diagnostic and treatment services directly accessible to primary care.

It is important that the development of rural service level alliance teams progresses during the year. It is expected that a rural service level alliance team develops and agrees a plan for the distribution of rural funding, in accordance with the PHO Services Agreement Version 2 (July 2014).

Health of Older People
I am pleased to note your commitment to continuing price or volume increases in home and community support services, implementing your fracture liaison service, and using interRAI-based quality indicators.

Regional and National Collaboration
Greater integration between DHBs supports more effective use of clinical, financial and other resources (such as technology). In particular, clinically-led collaboration across DHBs is essential, as sharing of expertise will contribute to the realisation of regional and sub-regional benefits. I expect DHBs to make significant contributions to delivering on regional planning objectives, and to priorities specific to their regions, that will help lead to financial and clinical sustainability.

DHBs have also committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to factor in benefit impacts for the Finance Procurement Supply Chain Initiative where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

Budget 2014
I also expect that you will deliver on Budget 2014 initiatives. This includes extending free doctors' visits and prescriptions for children aged under six to all children aged under 13 from July 2015.

Annual Plan Approval
My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you have a number of service reviews under way, including a tertiary services review. The National Health Board will contact you where these service reviews need further engagement. You are reminded that you need to advise the National Health Board of any proposals that may require Ministerial approval as you review services during the year.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2014/15 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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

The Statement of Intent covers the four year period: 1 July 2014 to 30 June 2018.

Foreword from the Chair and Chief Executive

The foundations are in place for the transformational change necessary for Auckland DHB. Our Board has been confirmed following the 2013 local body elections, our new management structure is in place and the building blocks for system integration are developing.

Following three years of significant change focused on 'getting our house in order' along with performance and quality enhancement, we are now well placed to actively recalibrate the model of care. 2014/15 will be the first year of a four year strategy working with our partners to empower patients, families, whānau, and our local communities. Empowerment recognises that the more control we have in our lives, the better able we are to make healthy choices and to determine the kind of health and disability care that is right for us.

The vision of Patient and Whānau Determined Health requires a deliberate shift of power, to one where health professionals increasingly support people to achieve their health goals, as opposed to 'doing things' to or for them. In practice we will see an evolution in our model of care with the residents of Auckland becoming more engaged in managing their health; patients determining how care is provided for them; and staff energised by working with patients and whānau as partners in a whole system way.

Implicit in our work is making sure everyone in our district has the same opportunity for good health and independence. Some groups are missing out and these are the people we see in hospital most often. All people living in the Auckland DHB area should have an equal opportunity to make decisions that allow them to live a long, healthy life, regardless of their level of income, education or ethnicity. Our health interventions will be prioritised towards people in our district who have the greatest need.

Our DHB is therefore helping to link PHOs, community health services, residents, community leaders and service users together in localities where there is high need. These local networks will build on the strength of these communities, support people to be healthy and independent, and they will be there to help at the first sign of problems thus reducing the long term impacts of ill health on individuals and their whānau. The benefits over the longer term will be healthier local communities, more work being done in the community, and fewer unnecessary contacts with hospital services. People will feel more confident managing their health and will have the information and skills they need to look after themselves and their whānau. Reduced demand on hospital services will allow us to better manage the growth in hospital-related expenses.

Over the past year we have built in more clinical leadership and greater accountability for health outcomes. Our systems and processes are now orientated to supporting health services and to achieving the vision of patient and whānau determined health by enabling and empowering those who directly serve them. We have some outstandingly good services provided directly by ourselves and by others. We are proud to be the DHB with the best performance in the country on the 'More Heart and Diabetes Checks' target for both our Māori and Pacific populations.

We will draw on the strengths of our services and the commitment and professionalism of the staff within them to achieve our objectives. We have core tasks to fulfil:

- Maximise health and wellbeing

- Provide safe, high quality, effective and sustainable services for the Auckland population
- Provide safe, high quality, effective and sustainable tertiary and national services for the people of New Zealand and some Pacific nations.

All activities across our health system, from work within our communities to tertiary and national services, must be covered within budget, and be safe, high quality, effective and accountable. We must be clear about the scope and cost of services we are providing to other DHBs and the training opportunities we offer and match this to the resources available. We will focus on ensuring the quality of our decision making, actions and service provision is not only high but can also be demonstrated to be so.

As a public entity we need to use resources prudently and sustainably. In order to get the best results from the resources available to us, we will commit to a four-year plan with the following priorities:

1. Commit to Patient and Whānau Determined Health as a strategic direction with clear expectations for the long term
2. Get more community-based services underway where these are needed most
3. Deliver hospital services more efficiently.

An enduring efficiency and transformation programme is of the highest priority. This is challenging (but essential) to sustain as it is layered on very significant efficiency programmes over the last two years. The financial challenge is not one that can be sustainably solved by efficiency programmes – service transformation and new models of care are vital to reduce the 'cost curve' as the Auckland DHB moves into the future. The legacy cost structures inherited three years ago are simply not well suited to a contemporary, adaptive health system. Difficult decisions will need to be made with careful consideration of the evidence – maintaining the status quo is no longer a viable option.

Nonetheless we must lift our gaze beyond the problems associated with managing services to a long term strategy with a unified vision which focuses our attention upstream where the causes of pressure in the health system lie. We need to limit the growth in demand for hospital beds, we need more active prevention work in the community and we will do more to stem the flow of admissions to hospital for conditions that could be managed better and more effectively in general practice. We understand that Patient and Whānau Determined Health, which includes Whānau Ora, requires wrap-around services for the most vulnerable people in our district.

In 2014/15 we will move with urgency to ensure there is greater capacity for primary and community based staff to draw on the skill of those traditionally based in hospital. The real breakthroughs for healthcare lie in collaborations and whole system work focused on supporting patients and whānau to get the outcomes they want.

The challenge is both significant and urgent but we are building on great strengths and a strong sector wide commitment to support the populations of Auckland and New Zealand to maximise their health and wellbeing.

Dr Lester Levy
Chairman
Auckland District Health Board

Ailsa Claire
Chief Executive
Auckland District Health Board

Te Tiriti o Waitangi Statement

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

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

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

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

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

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

Guiding Principles

The following eight 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 memoranda 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).

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. 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

Health equity is concerned with eliminating disparities in health outcomes. 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

Ngā kaupapa tuku iho requires acknowledgment and respect for Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning 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 judgment, 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 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 hospital care services
- Promote effective care or support of those in need of personal health services or disability support.

The Auckland district encompasses seven complete local board areas and parts of two others within the Auckland Council. Approximately 475,750 people live in Auckland DHB and this number is growing due to the inwards migration of people to the Auckland district.

Of paramount importance is making sure that patients and whānau determine the kind of help they need and the way this is delivered. We know that tailoring our help to the individual and the things that matter to them, gets the best results. This requires a health workforce that empowers people and shows real flexibility in responding to individual needs. A snapshot of the Auckland population is provided in the box on the following page.

We commit to the Government's health plan and the Minister of Health's expectations for 2014/15. Our high performance against the six health targets will continue in 2014/15. We propose to

establish a new Auckland and Waitemata District Alliance as the governance body for service integration. PHOs, DHBs, Manawhenua and Mataawaka partners will make sure that PHO and hospital services meet local needs. A work programme will follow that supports locality work, fosters better clinical leadership, and drives service improvement.

Snapshot of Auckland DHB

- Over 475,750 people live in our DHB area, with a projected growth of 16% or 75,850 more people by 2026
- We are a diverse population: 7.7% Mäori, 10.9% Pacific, 31.4% Asian[1], 50% Pakeha and other New Zealanders
- Auckland has one of the highest non-English, non-Māori speaking areas with over 100 languages spoken
- 13% of our population do not speak English and need assistance or interpreting when attending health services
- Our population is relatively young: 16.6% are aged under 15 years, compared with 19.7% for all of NZ; and 10.3% of people living in the Auckland DHB district are aged 65 years and over, compared with 14.72% 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 Māori and 21% are Pakeha and other New Zealanders
- Cancer, heart disease and mental health remain the diseases placing the biggest health burden on our district
- The life expectancy gap for Māori is 7 years and for Pacific 9 years between these groups and other New Zealanders living within the Auckland 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.

Opportunities and Challenges

Across the Auckland region there are similar kinds of challenges:

- Population growth and ageing
- Increasingly diverse communities
- Increasing prevalence of long term conditions
- Growing demand for health services (impacting workforce and infrastructure)
- Inequalities in access to services, healthcare interventions and health outcomes.

As we grow, our DHB needs to respond while working in a fiscal environment where health spending is expected to be constrained. The challenge is to enhance quality health service delivery against this economic background.

[1] For the purposes of this Annual Plan, the term 'Asian' describes culturally diverse communities with origins from the Asian continent and refers to Chinese, Indian, Southeast Asian and other Asian people excluding people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. The term 'MELAA' refers to Middle Eastern, Latin American or African ethnicity groupings consisting of extremely diverse cultural, linguistic and religious groups.

In partnership with the other northern region DHBs we have a common interest in getting best health outcomes from the available resources. We will continue to focus on:

- Changing service models and models of care (what is done where and how)
- Improving labour productivity through inter-disciplinary team work, skill mix and enabling staff to work at top of scope
- Reprioritising towards more cost-effective treatments.

Key areas of risk and opportunity

Risks	Mitigations/ opportunities
Long-term fiscal sustainability	Patient and Whānau Determined Health Whole system management, integration and partnering 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 the whole system Use of evidence based care to avoid wastage Service reconfiguration to support improved national, regional and local service delivery models, including greater regional cooperation. Matching training capacity and costs
Diversity of need within New Zealand's population, including a growing number of older people with multiple conditions	Engaging patients, consumers and their families and the community in the development and design of health services and ensuring our services are responsive to their needs. Assisting people and their families to manage their own health in their own home, supported by specialist services delivered in community settings as well as hospitals and increasing our focus on proven preventative measures and earlier intervention.
Growing demand for health services	Accelerating the pace of change, in key areas such as: • Patient and Whānau determined care • Moving intervention upstream • Improved models of care • Integrating services (the coordination of care, systems and information) to better meet the outcomes people want • Improving performance and implementing evidence based practice • Strengthening leadership while supporting front-line innovation • Integrated contracting • Working regionally and across government to address health and other priorities • Working as a whole of system health service, inclusive of non-government organisations, primary care, community, hospitals and funders.

Strategic Intentions

Patient and Whānau Determined Health

Patient and Whānau Determined Health is a draft vision that will direct Auckland DHB work over the next four years. This draws Whānau Ora and Self Directed Care into one patient and whānau-centred approach. People are the heart of the strategy for Auckland DHB. We put patients and whānau first; we respond to individual needs; we see people in the context of their whānau, their family, social support networks, and communities of interest.

Control and autonomy are central to wellbeing. Over the next four years we will see more work done in a way that empowers the people we work with. We want people to be the experts in their

own health and to drive the health improvements that they and their families and whānau most value. This is Patient and Whānau Determined Health in action.

We must ensure our actions are not disempowering, keeping people helpless and dependent on health services. We want to see Aucklanders enabled to take more responsibility for their own health, at home and in their neighbourhoods and in the everyday places where real health belongs. Everyday lifestyle choices make a big difference to individual health and to reducing overall population rates of cancer, heart disease (cardiovascular disease), stroke (cerebrovascular disease) and diabetes.

When problems arise, we want patients and their whānau to determine the best approach for them. Health care is personal. We have learnt that when we respond to the things that matter most for each individual patient, we radically improve their experience of the health system and reduce the resources utilised. As a result we have to do more to encourage patients, their families and support people to participate in health care decisions and in the treatment process.

We will provide care to all in need with particular attention to people who are most disadvantaged, those who have not had the same opportunity as others for education, employment or security and who need our help. The bottom line is a health system oriented to people; where staff work in partnership with ease across service borders and where every health intervention helps to motivate and empower people.

Strategic Work for 2014/15 and beyond

In this first year of our four year strategy, we will fulfil our responsibilities as a district health board:

1. Maximise health and wellbeing
2. Provide safe, effective and sustainable services for the Auckland population
3. Provide safe, effective and sustainable tertiary and national services for the people of New Zealand and the Pacific.

In order to improve health status across the population of Auckland we will lift our focus upstream where problems and strengths are generated. The positive contributors to good health lie in the family where lifestyle habits are engrained. We know that eating well; regular exercise; feeling safe and secure and having a sense of identity, belonging and purpose are critical to wellbeing. The size and scale of the changes required here is significant. Our strategy for lifestyle change will run over the long term. However some actions can have rapid benefits for individuals, whānau and the health system.

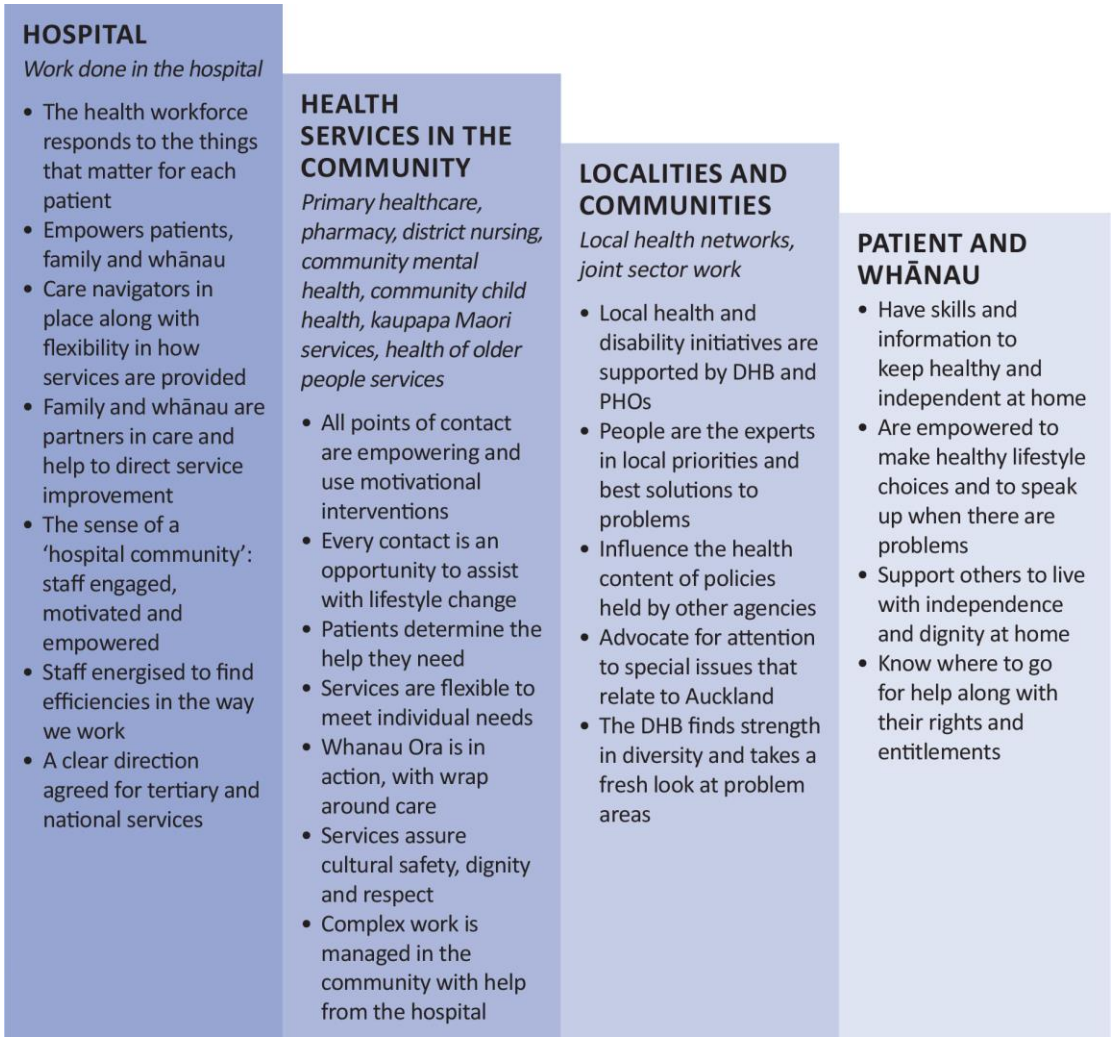
We will do more with local government and with the Ministry of Social Development and other policy makers to make Auckland a healthier city. The localities programme of work needs to continue so that we help to build health networks in the neighbourhoods where people live, work and play. This work will focus on the local boards of the city where people have the greatest socio economic disadvantage. Work in the community is approached from a strength base. We understand that local communities are the experts when it comes to identifying problems and coming up with workable solutions.

As a major provider of health services, Auckland DHB is committed to providing the best health care to our local people. We are also committed to providing high quality services for the 212,000 or so people from outside the Auckland DHB area who come to Auckland City Hospital, Starship or Greenlane Clinical Centre each year for treatment.

Our commitment to Patient and Whānau Determined Health requires us to work in more empowering ways with patients. Across the system, we expect staff to design services in partnership with patients, family and whānau. We will do more to involve family and whānau as partners in care, which means expanding the hospital-based projects started in the 2013/14 year.

We will also enable more patient and whānau determined health through increasing health literacy, through patient initiated care plans, and motivational interventions that help patients achieve the goals that they determine are priorities.

Patient and Whānau Determined Health in every setting



During 2014/15 we will develop Patient and Whānau Determined Health into a longer term strategy for Auckland DHB. The strategy will be shaped by inputs from staff, patients, providers, localities, our iwi partners and a great many other stakeholders. The various streams of work required to put patient and whānau determined health into action need the involvement of people across every health setting. This work will be completed by December 2014 and will set the work programme for the 2015/16 Annual Plan. Therefore Auckland DHB will submit a refreshed Statement of Intent (Module 1) in 2015/16.

System integration

Over the course of the coming years, we will do more to have our local health system working as one.

In the short term we will continue our focus on better service integration across the whole health and wellness system. In part, this requires general practitioners (GPs) being able to draw on the expertise normally based in hospitals. It also requires processes to be put in place to support people and families to navigate the system with a focus on the achievement of their care plans. Patient and Whānau determined care needs to be supported in the community, by GPs working with non-

government organisations (NGOs) and with other local health and disability services. As an immediate start we will work with other sectors to achieve the Better Public Services targets set for health:

- The Prime Minister's Youth Mental Health Project
- The Children's Action Plan
- Increased Immunisation Health Target
- Reduced rates of Rheumatic Fever.

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

- Improving relationships between the DHB and primary care through an Alliance
- Building capability and capacity of primary care
- Driving performance through quality improvement and transparent reporting
- Developing innovative funding models that enable and support sustainable service change
- Organisation culture and norms of behaviour that support redesign processes and clinical leadership
- Priority focus on Māori, Pacific and other high need populations.

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

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

We will also contribute to the achievement of the Health Quality and Safety Commission, Health Workforce New Zealand, Health Benefits Limited (HBL) and National IT Board objectives including:

- Improving the quality and safety of health services and minimising patient harm
- Supporting implementation of national IT initiatives such as shared care and e-prescription services
- Supporting workforce development initiatives.

We now have overt clinical leadership of services to integrate work across community and hospital based care. Our senior management team is organised to have a single line of accountability for outcomes.

The DHB is committed to staying within budget and remaining on a sustainable financial path into the future. However, this will be extremely challenging in the current fiscally constrained environment that is also characterised by increasing demand for services (reflecting our population demographics) and operating costs and capital related costs growing at a pace faster than the funding growth. Our savings programme, focused on sustainability and transformation, continues with urgency. It is imperative that we shift our focus more to reviewing the models of care and redesigning the way we deliver services, as doing what we have done in the past is no longer affordable, nor sustainable.

Nature and Scope of Activities

District Health Boards have five key roles to deliver on their objectives. The 'Health Outcomes' and 'Funder' roles are undertaken by the same team for both the Auckland and Waitemata DHBs, hosted by Waitemata DHB:

- **Health Outcomes -** DHB planning begins with the assessment of population health need. Health needs assessment, along with input from our key stakeholders (including our community), establishes the important areas of focus within our district which are balanced alongside national and regional priorities. These priorities inform the Northern Region Health Plan, which sets the longer term priorities for DHBs in the northern region, as well as our DHB Strategic Plan, DHB Annual Plans and the Māori Health Plan.

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

- **Funder -** DHB responsibilities include purchasing the publically funded community-based and hospital services for our population while delivering both value for money and living within our means. As a Funder, Auckland DHB needs to work with other DHBs to determine the pattern, scope and price of those tertiary services available to the population of New Zealand and the Pacific. This approach shares the responsibility for the specification of tertiary services with the DHBs that need the services for their local population.

- **Provider -** Auckland DHB provides specialist hospital and community health services to people living in our district and to people from other parts of New Zealand. Services are delivered from Auckland City Hospital (New Zealand's largest public hospital and clinical research facility), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. Other services provided by Auckland DHB include community child and adolescent health and disability services, community mental health services and district nursing.

  The Provider is required to respond to Funder specifications about the scope of all services it provides including the tertiary services available to people from other DHBs and from the Pacific nations.

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

- **Leadership of the health community -** The DHB provides leadership of the health community, working with partners both within the community and others whose roles can significantly impact on 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.

Other interests

Auckland DHB Charitable Trust (A+ Trust) is an independent charitable trust created by Auckland DHB. The Trust is 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 DHBs are limited partners in the New Zealand Health Innovation Hub. The Northern Region Alliance is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in four equal shares by Waitemata, Auckland, Counties Manukau and Northland District Health Boards.

Health Benefits Ltd (HBL) is a crown company that was set up in 2010 to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Any savings will go back into supporting frontline health services. HBL works with DHBs to achieve these aims.

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

Strategic outcomes in national and regional context

National

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

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

For 2014/15 the Minister of Health requires continuing focus on the following priorities:

- **Better Public Services –** leading the effort to increase immunisation, reduce the incidence of rheumatic fever and reduce violent assaults against children
- **National Health Targets –** committing to achieve the six national health targets
- **Care closer to home –** better integration and coordination of health services between community and hospitals particularly for management of long term conditions and for the health of our older people to support their independence
- **Regional and national collaboration –** to leverage the financial and clinical gains to be derived from working together
- **Living within our means –** to support the Government achieving a surplus.

The DHB will support National Health Committee technology, clinical research and burden of disease work programmes as required during 2014/15. The PHARMAC managed Hospital Medicines List was implemented at Auckland DHB in July 2013 and nationally is still in the transition phase.

Regional

The Northern Region Health Plan has been developed by the four Northern Region DHBs. The Plan sets out three priority goals, these are:

- Goal One – First, Do No Harm: reducing harm and improving patient safety
- Goal Two – Life and Years: reducing disparities and achieving longer, healthier and more productive lives. This year there is a particular emphasis on child health, health of older people and reducing inequalities for Maori, Pacific and other population groups
- Goal Three – The Informed Patient: ensuring patients are better informed about care and treatment choices and healthcare providers are better informed about patients' care preferences, particularly around end of life care.

The Northern Regional Health Plan can be located here:
http://www.NDSA.co.nz/FormsDocuments.aspx)

Sub-regional

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

Planning Framework

The planning framework for Auckland DHB on the following page summarises the key national, regional and local priorities that inform this 2014/15 annual plan, including the key measures we monitor to ensure we are achieving our objectives.

Planning Framework

GOVERNMENT PRIORITIES	NEW ZEALANDERS LIVING LONGER, HEALTHIER AND MORE INDEPENDENT LIVES		THE HEALTH SYSTEM IS COST EFFECTIVE AND SUPPORTS A PRODUCTIVE ECONOMY	
MOH Priorities	**Minister's Health Targets**	**Better Public Service**	**System Integration**	
Northern Region Triple Aim	Health services are integrated, more convenient and people centered	New Zealanders are healthier and more independent	Future sustainability of health system is assured	
ADHB Vision	**Patient and Whānau Determined Health** Achieving the outcomes people want for themselves, their whānau and their communities			
ADHB Priorities	Maximise health and wellbeing across our population	Provide safe, effective and sustainable services for people living in Auckland	Provide safe, effective and sustainable tertiary and national services for the people of NZ and the Pacific	
Output classes	Prevention	Early Detection and Management	Intensive Assessment and Treatment	Rehabilitation and Support
Enablers	Patient and Family empowerment	Workforce	Information and Communication Technology	Facilities

Outcomes Framework

Our outcomes framework enables the DHB to ensure it is achieving its vision and delivering the best possible outcomes across the whole system for our population. Our framework is based on the 'Triple Aim' – population health, patient experience and cost/productivity. These are based on our role and function as a district health board and align to the Northern Region Health Plan and World Health Organisation guidance for health system performance measurement and improvement.

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

Key to Outcomes Framework

Acronym/Term	Definition
ABC	**Ask** about smoking status, to give **Brief** advice to all smokers to stop smoking and to provide evidence-based **Cessation** support for those who wish to stop smoking
CVD	Cardio-vascular disease
DCIP	Diabetes Care Improvement Package
Impact	Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both (Public Finance Act 1989, s2). It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations
Outcome	Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. However in common usage the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but, in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome
Outputs	Final goods and services, that is, they are supplied to someone outside a Crown Entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (New Crown Entities Act 2004 s136(1)(a – c))
QALYs	Quality-adjusted life years is a measure of disease burden, including both the quality and the quantity of life lived.

Outcomes Framework and Intervention Logic

VISION	PATIENT AND WHĀNAU DETERMINED HEALTH		
Triple Aim	**Population Health • Patient Experience • Financial Sustainability**		
Overall Measures	**Increase Life Expectancy and Quality of Life**		**Reduce Ethnic Inequalities**
Outcome Measures	• CVD Mortality • Cancer Mortality • Obesity prevalence • Suicide Rates • Infant mortality	• Better Patient Experience • Elective QALYs • Hospital Mortality	• Staying within Budget
High Level Impact Measures	• % CVD checks • Smoking ABC • % Screened (breast and cervical) • Rheumatic fever cases • Access to mental health	• Patient Experience Score • Elective Discharges • ED waiting times • Healthcare Acquired Infections	• Acute Inpatient Bed Days per capita • Ambulatory Sensitive admissions
Outputs	• No. smoking advice given • No. children swabbed • No. CVD checks • No DCIP Annual Reviews • No People screened	• Elective Discharges • ED Attendances	• Staff employed • Outpatient attendances • Inpatient attendances
Priority Programmes	• Smoking • Childhood Immunisations • Well Children • Rheumatic Fever • CVD/Diabetes Checks and Management • Cancer Screening • Mental Health	• Shorter stays in ED • Access to Electives • Faster Cancer Treatment • Patient Experience • Quality and Safety • Health of Older People	• Living within our means
Priority Populations	Maori	• Pacific	• Asian
Output Classes	**Prevention**	**Early Detection and Management**	**Intensive Assessment and Treatment**	**Rehabilitation and Support**

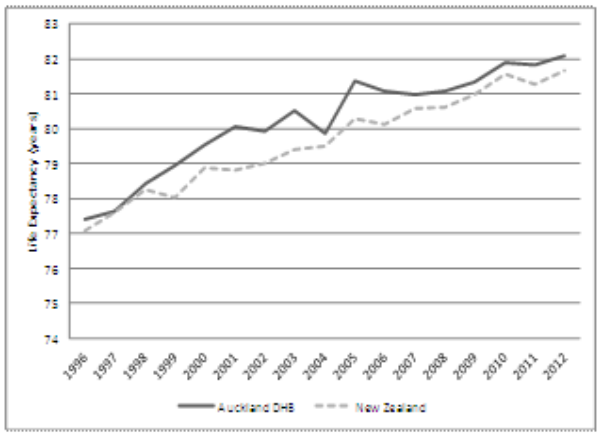
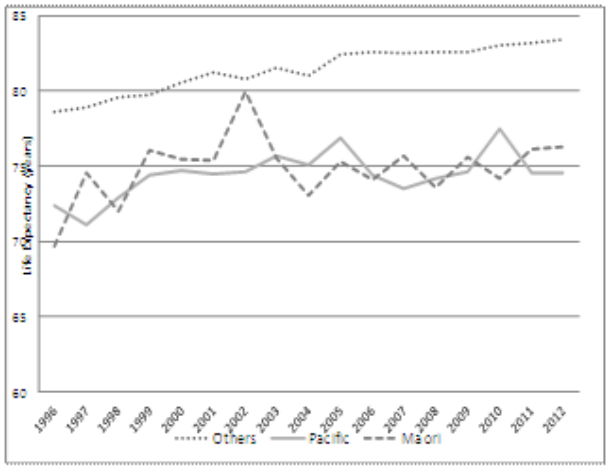
We will refine this framework and develop metrics and a reporting process by working with our clinical leaders and primary care and MOU partner. The measures included in our outcomes framework will be updated through this process. We intend to align this to the Integrated Performance Improvement Framework (IPIF) as it is developed. The Strategy work in progress will also lead to changes in outcomes measures and this will impact the 2015/16 Annual Plan and beyond. The Statement of Performance Expectations in Module 3 sets out a more detailed set of indicators that contribute to our overall outcomes framework.

Overall Outcomes

The overall outcomes that we want to achieve are to increase life expectancy and quality of life (measured by life expectancy at birth) and to reduce ethnic inequalities (measured by the ethnic gap in life expectancy). Measures for the quality of life are less well developed so we have not currently identified a single overall measure of quality of life. However a number of measures in our outcomes framework will contribute to quality of life. Mental ill health in particular is a major cause of disability and distress that significantly reduces quality of life. In future years this outcomes framework will be closely aligned to our Auckland DHB strategy. The strategy development work is currently underway.

Key

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

Overall Outcome – Increase Life Expectancy and Quality of Life	
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 2012 life expectancy in the Auckland DHB area was approximately 82 years.	**Outcome Measure - Life expectancy at birth, ADHB and New Zealand** ✔ 
Overall Outcome – Reduce Inequalities for all populations	
There are significant differences in life expectancy rates between ethnic groups within our district. Māori and Pacific people have a lower life expectancy compared to other New Zealanders, with a gap of 7 years for Māori, and 9 years for Pacific. Our target over the coming years is to reduce this gap in life expectancy for Māori and for Pacific compared to other New Zealanders. Cardiovascular disease, lung cancer, diabetes and obesity accounted for over half the difference in life expectancy between Māori and Pacific people when compared to European ethnicities in Auckland and are reflected in our outcome areas.	**Outcome Measure - Ethnic trends in life expectancy at birth, Auckland DHB** 

To Maximise Health and Wellbeing – people will be supported to be healthier and take greater responsibility for their own health

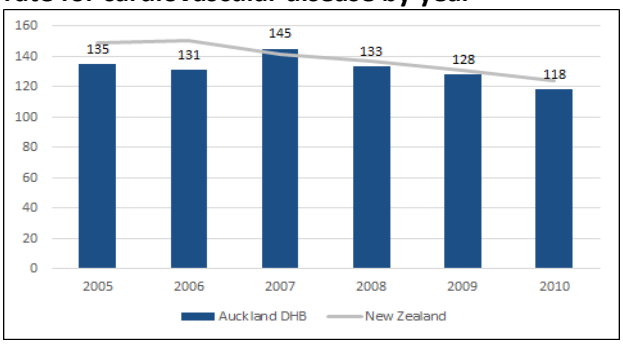
In order to maximise health and wellbeing we want to see Aucklanders taking more responsibility for their own health, at home and in their neighbourhoods and in the everyday places where real health belongs. It is the everyday lifestyle choices that make the difference to individual health and to reducing overall population rates of cancer, cardiovascular disease and diabetes. We need to improve detection and management of these diseases as well as ensuring rapid assessment and treatment for patients when they are ill. When problems arise we want patients and their whānau to determine the best approach for them. Over the next 4 years our main measures of these activities, including inequity of outcome, are as follows.

Outcome - Reduced mortality from Cardiovascular disease (CVD)

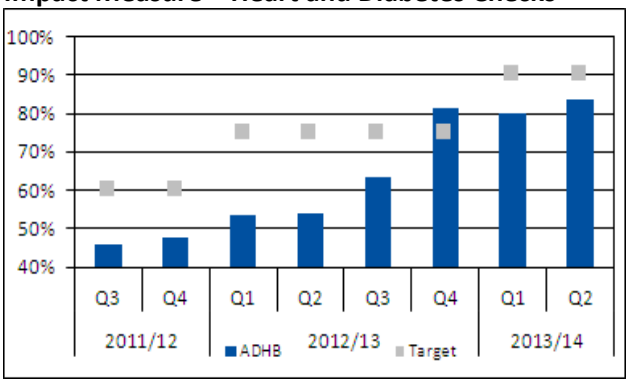
Cardiovascular disease is the leading cause of death in Auckland and is largely preventable with lifestyle change, early intervention, and effective management. Cardiovascular disease is exacerbated and compounded by diabetes. 23,649 residents live with diabetes and the number is increasing. Ethnic differences persist and long term conditions rarely occur as single disease.

Good progress is being made to meet the heart and diabetes check target. Management of blood pressure, cholesterol, blood glucose levels (HBA1c), retinal screening and diabetes patient education can significantly reduce cardiovascular mortality and improve health outcomes.

Outcome Measure - Age standardised mortality rate for cardiovascular disease by year



Impact Measure – Heart and Diabetes Checks

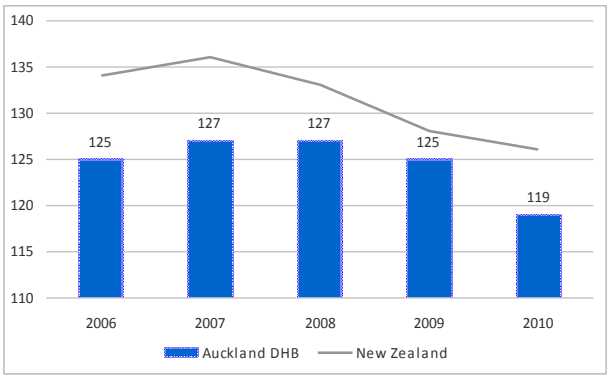


Outcome – Increase Survival and Reduced Mortality from Cancer

Cancer is the second largest cause of death in Auckland. Auckland DHB's one year total cancer survival rate is 78.6%, which is one of the highest in the country. On average, there were 1745 people diagnosed with cancer per year in our district from 2008-2010.

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

Outcome Measure – Age standardised mortality rate for cancer by year



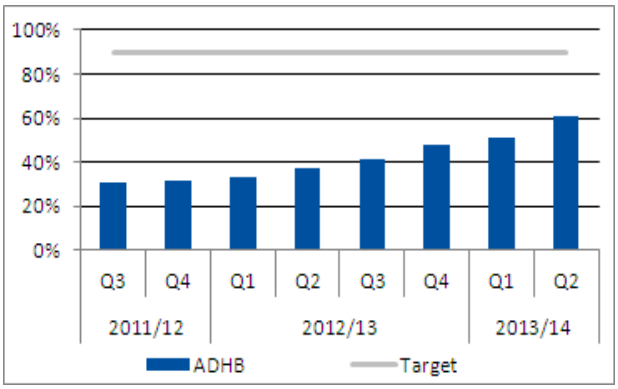
Outcome – Increase Survival and Reduced Mortality from Cancer

likely to smoke (26.3% and 21.9% respectively).

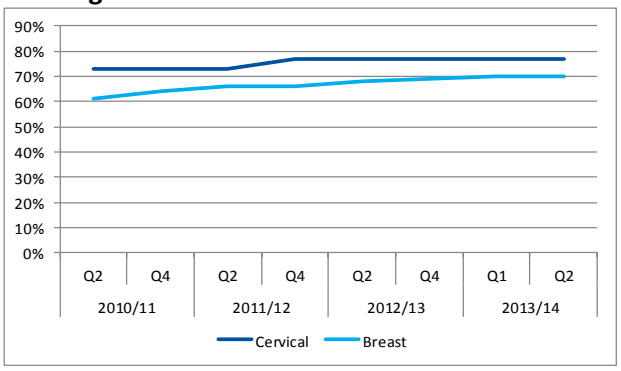
We have performed very well providing brief advice to smokers in hospital but more effort is required to ensure that smokers in primary care are supported to quit smoking.

Breast and cervical screening programmes identify cancers in these areas and enable early treatment of disease. Uptake of cancer screening programmes has been increasing but can be further improved. Similarly rapid diagnosis and treatment of cancer which is the focus of the 62 day referral to treatment target increase the options for treatment and increases the chances of survival.

Impact measure – Smokers in primary care given brief advice to quit



Impact Measure – Breast and Cervical Screening Coverage

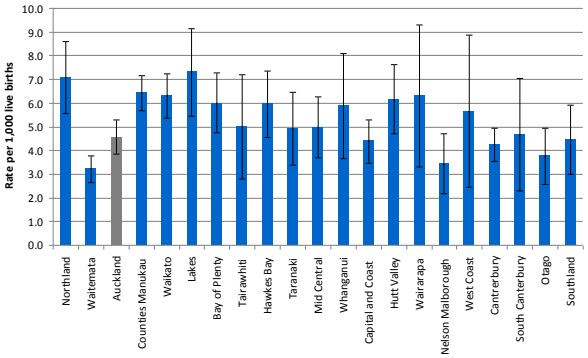


Outcome – Children get the best possible start in life

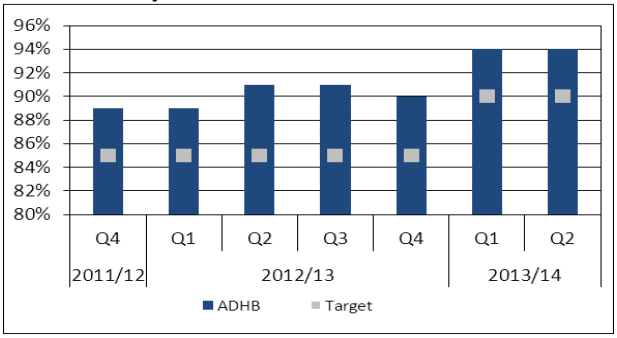
The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. Healthy children are more likely to become healthy adults. Positive health outcomes for children and mothers are essential for this. Auckland DHB's infant mortality rate of 4.6 per 1000 live births (2006-2010) is similar to other districts. Between 2008 and 2010 Auckland DHB had 0.8 deaths per 1000 live births as the result of sudden unexplained death of an infant (SUDI), similar to other DHBs. The most recent data suggests that deaths from SUDI are beginning to decline.

Auckland DHB now has one of the highest immunisation coverage rates in New Zealand - 94% of Auckland children were fully immunised at 8 months in quarter 1 2013/14. This needs to be continued and sustained over the coming years.

Outcome Measure – Infant mortality



Impact Measure - Proportion of 8 month old children fully immunised ✔

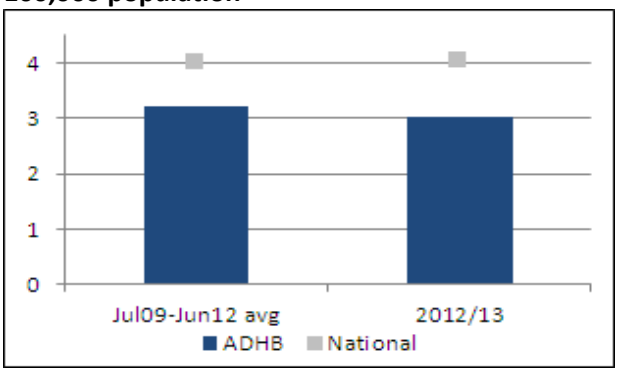


Outcome – Increase Survival and Reduced Mortality from Cancer

Considerable effort will also be required to reduce the number of assaults against children.

Auckland DHB acute rheumatic fever baseline 3 year rate was 3.5/100,000 of population (16 cases) as at 2011/12. We have made significant progress implementing Rheumatic Fever responses during 2013/14, including training health professionals and putting systems in place to obtain monitoring data to support ongoing analysis. We have also undertaken reviews of all cases of acute rheumatic fever in order to systematically understand and address the modifiable factors which contribute to rheumatic heart disease. We intend to continue these efforts in the coming years to further reduce rheumatic fever rates within our population – aiming for no more than 1.2 episodes per 100,000 of the population by 2017/18.

Impact Measure – Rheumatic Fever rates per 100,000 population ✔

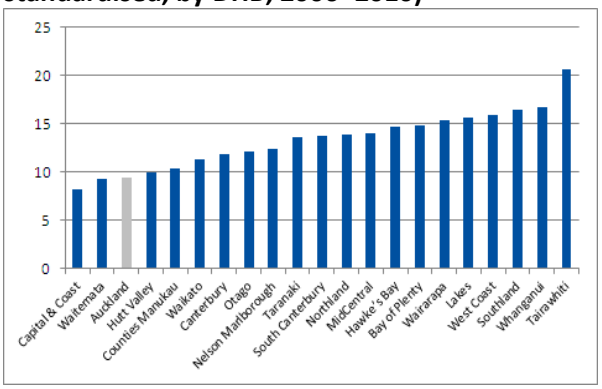


Outcome – Reduced morbidity and mortality from mental illness

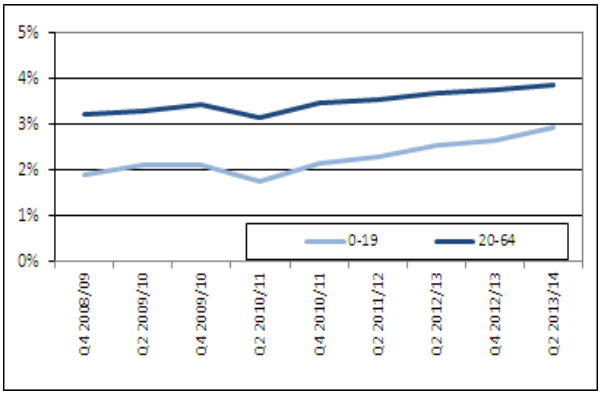
Mental ill health is one of the leading causes of disability and overall health loss. Nationally one in 5 people have suffered some kind of mental illness in the last year and 3% have suffered from a serious mental illness. Approximately 45 -50 people die as a result of suicide each year in the Auckland DHB district, a disproportionate number of who are young and Māori.

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

Outcome Measure - Suicide rates (age-standardised, by DHB, 2006–2010)



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



Better Patient Experience - people will receive timely, safe, high quality services when they need them.

We have a significant role to play in providing safe, high quality care. People who use our services should have a high level of trust and confidence in the health system and rate their experiences positively. We need to ensure rapid access to diagnosis and treatment for patients and consumers and a smoothly integrated transition between the providers of care.

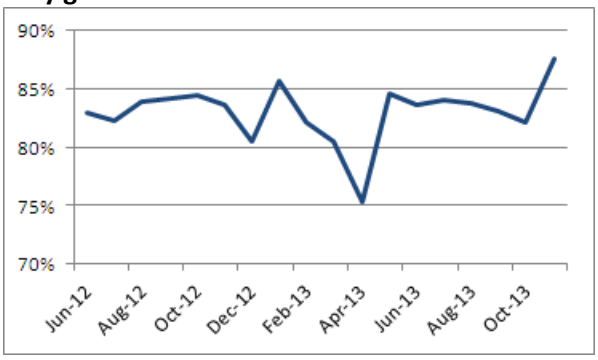
During 2014/15 we will develop targets, measures and a reporting system to support our commitment to Patient and Whānau Determined Health. The metrics will include process measures, intermediate and long term outcome measures. Our main measures to ensure we are providing safe, high quality care and reducing inequity are set out in the following pages.

Outcome – Better Patient Experience

Putting patients and whānau first ensure we deliver the care that is empowering and is oriented to the things that matter to each patient. 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.

Services 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 patient experience ratings while decreasing costs.

Outcome Measure – Percentage of patient survey respondents who rate their care and treatment as very good or excellent

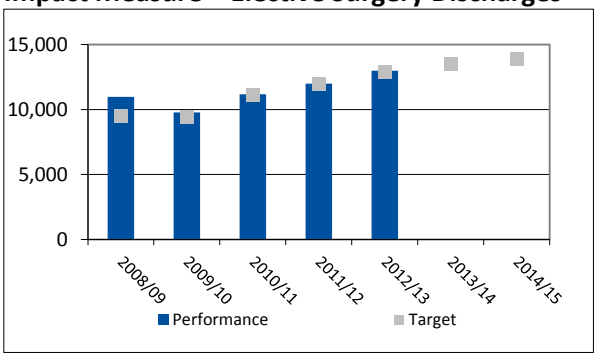


Outcome – Timely Access to Hospital Services

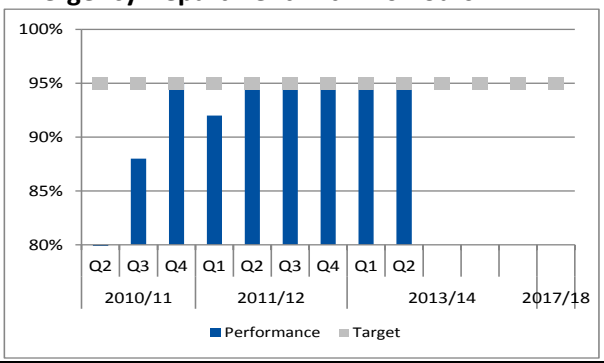
We want to provide timely access to hospital services to enable people to live longer, healthier and more independent lives. Elective surgery increases quality of life because it remedies or improves disabling conditions. The increasing elective health target has been consistently met for the last three years.

We are consistently admitting, discharging or transferring 95% of patients from our emergency departments within 6 hours.

Impact Measure – Elective Surgery Discharges ✔



Impact Measure - 95% of patients will be admitted, discharged or transferred from the Emergency Department within 6 hours ✔



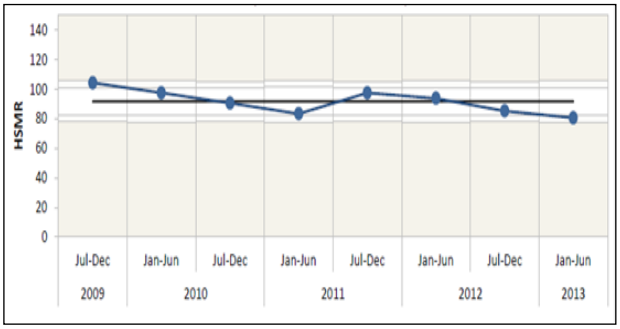
Outcome – High Quality and Safe Services

Patients and families need to be confident of the quality and safety of the care they will receive. The care provided is flexible and can respond to the things that matter most to each patient. Care is based on patient engagement and choice and informed by best practice and the evidence base. Patients get just the appointments they need and are well informed every step of the care plan.

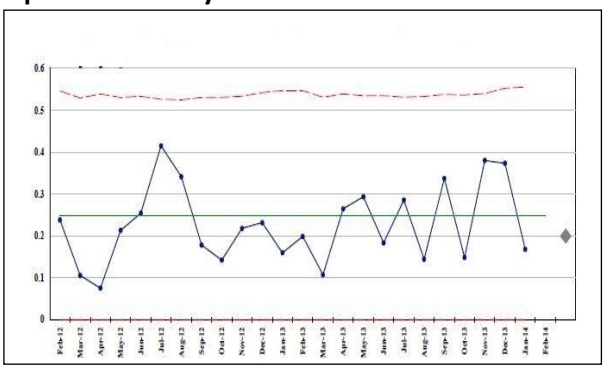
We will improve quality and safety through implementing the First Do No Harm programme, being open and transparent and monitoring the Health Quality and Safety Commission's quality and safety markers (QSMs) regularly striving to improve in the four areas of harm covered by the campaign:

- Falls
- Healthcare associated infections (hand hygiene, central line associated bacteraemia and surgical site infection)
- Perioperative harm
- Medication safety.

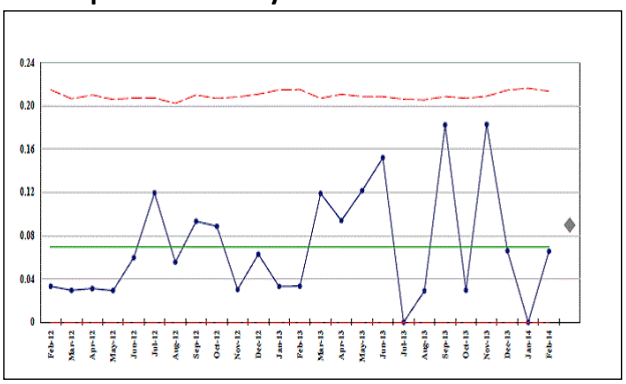
Outcome Measure – Hospital standardised mortality ratio ADHB compared to 4 year average



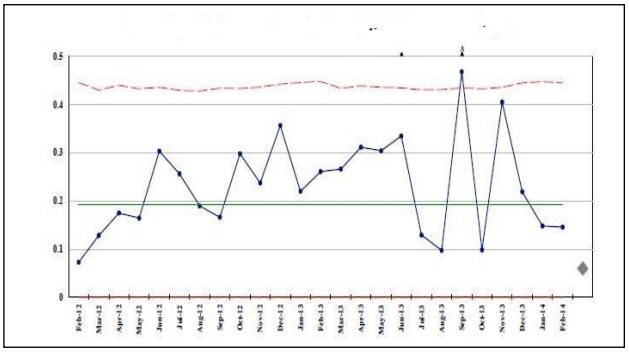
Impact Measure – Healthcare associated Staphylococcus aureus bacteremia per 1000 inpatient bed days



Impact Measure – Falls resulting in major harm per 1000 inpatient bed days



Impact Measure – Reported adverse events causing harm per 1000 bed days



Financial Sustainability – efficient and effective delivery of services

In addition to ensuring we improve health outcomes for our community we are also focused on the sustainability of our organisation. We are focused on ensuring that our services are provided in a financially sustainable manner and to that effect we will continue to manage our resources efficiently. Our main measures to ensure we are providing financially sustainable services.

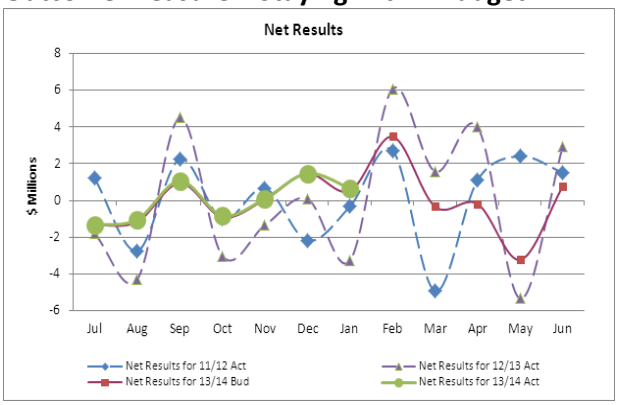
Outcome – Financial Sustainability

Over the past five years, we have managed to contain cost growth to within funding levels with the rate of cost growth slowing in the last couple of years. We have lived within our means achieving breakeven results each year. In the face of reducing funding growth, we have been able to contain costs to affordable levels by providing services in a more efficient and cost effective way. This has been achievable through business transformation and performance improvement initiatives identified and implemented by our staff and savings realised from national and regional initiatives.

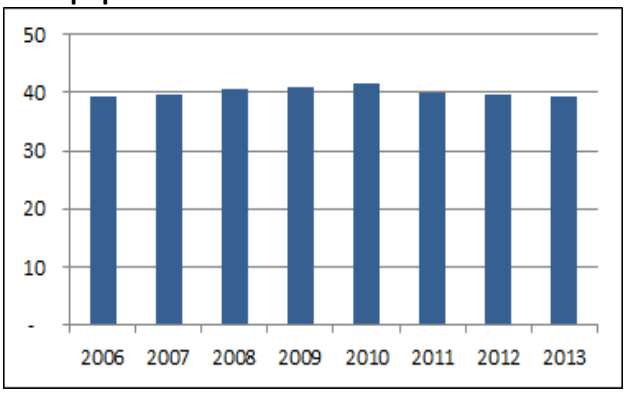
However the coming financial years will be particularly challenging, especially in the provision of tertiary services. DHBs are required "to ensure they seek the optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs"[2] and are also required to operate in a financially responsible manner. To that end, we are committed to continuing to cover all our annual operating and financing costs from our annual income.

As a Funder, Auckland DHB needs to work with other DHBs to determine the pattern, scope and price of tertiary services available to the population of New Zealand and the Pacific. This approach will ensure that tertiary services are not an Auckland issue. All DHBs require tertiary services for their local people. Similarly Auckland DHB requires the tertiary services provided by other DHBs for our local population.

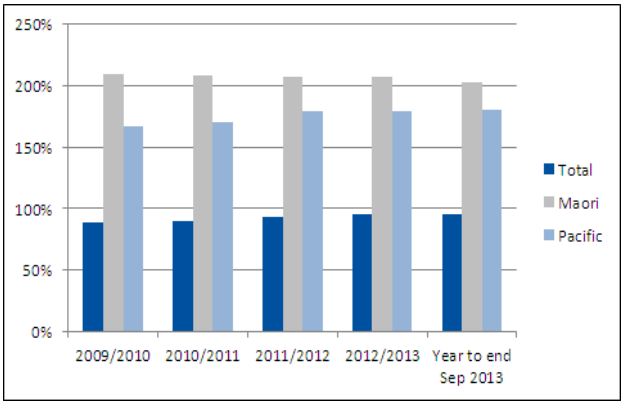
Outcome Measure – Staying within Budget



Impact Measure – Acute inpatient bed days per 1000 population



Impact Measure – Ambulatory Sensitive Hospital Admissions



[2] NZPHD Act 2000 Sec 22.1.ba

MODULE 2: Targets and Priorities

This module sets out how we will achieve the health targets, better public service targets, deliver on system integration and address government and board priorities.

Health Targets

Shorter Stays in Emergency Departments (ED)

What are we trying to do?

Auckland DHB will deliver high quality emergency care to our community by continuing to meet the health target (95% of patients admitted, discharged, or transferred from an ED within six hours). We will work with our partners to ensure only patients who need emergency care are seen in our ED.

Why is this important for community and patients?

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 delivers better outcomes and enables us to use our resources more effectively and efficiently.

Progress to date

We consistently achieve the 95% health target for all ethnic groups. The percentage of triage two patients meeting the Australasian College of Emergency Medicine triage sign on time of 10 minutes has risen from 70% in 2012 to 88% in January 2014 (target 85%). Our implementation plan to reduce our ED length of stay is supported by our senior management team and clinical staff. Daily reports are issued to all services on the previous 24 hours' target achievement: this allows for in-depth analysis of the cause of breaches. There is high visibility of performance in this area.

Combined ED and inpatient clinical documentation has been introduced to reduce duplication. We are redesigning our service delivery models to improve throughput. Clinical rosters have been reengineered to match staffing to peaks of patient presentation. Acute physiotherapy services are now delivered in the Adult Emergency Department (AED) and Admission and Planning Unit (APU).

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Emergency Department • Develop a low risk chest pain pathway to reduce admissions by 30 June 2015 • Work with the regional and national cardiac networks to develop accelerated chest pain pathways (ACPP) by 30 June 2015 • Complete the redesign of the ED medical and nursing roster to ensure it is better aligned with demand by 30 June 2015 • Develop new areas of practice for the nurse practitioner by 30 June 2015 • Ensure that all the mandatory components of the Quality framework are measured by 30 June 2015. ***Hospital*** • Continue the development of the bed	• 95% of patients admitted, discharged, or transferred from Emergency Department within six hours – monitored by ethnicity • The Emergency department be measuring all the mandatory components of the Quality framework by June 2015 • An implementation plan for key interventions of ACPP in place by 30 June 2015.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
forecasting tools and routines to support bed management, to minimise length of stay (LOS) and maximise throughput. Forecasting reports developed in Q1 2014/15 and business process aligned through Q1 and Q2. ***Community*** • Develop our district nursing model to provide new options for urgent care 3 month trial to start in May 2014 • Develop community based solutions as an alternative to inpatient admission. Two alternatives will be developed by 30 June 2015 • Continue to support PHOs and regional Primary Options for Acute Care (POAC) members across Auckland and the intravenous antibiotic therapy service in Aged Related Residential Care – on-going • Work with the Medical Officer of Health and Auckland Regional Public Health Service to develop local alcohol policies to reduce excess alcohol consumption in the community • Support the Medical Officer of Health in exercising statutory responsibilities under the Sale and Supply of Alcohol Act 2012 • Assist St Johns and primary care to develop referral pathways for urgent care as an alternative to transport to ED by 30 June 2015.	

Improved Access to Surgery

What are we trying to do?

Auckland DHB will ensure that our community is provided with timely and equitable access to both elective surgery (continuing to meet the health target and waiting time targets) and quality major trauma care to support our community to live longer, healthier and more independent lives.

Why is this important for community and patients?

Patients want certainty regarding access to elective surgery when they need it without having to wait too long for their assessment, diagnostic and treatment services. Patients and their referrers need to understand the process through which they receive surgery and know that it is fair. The community want to be sure that the DHB is working as efficiently and effectively as possible to deliver even more elective surgery than last year.

Progress to date

The increasing elective health target has been consistently met for the last three years. We implemented an Elective Services improvement programme containing four work streams. Three work streams are focused on the redesign of elective pathways and the fourth on developing effective resource management tools and routines to plan surgery for the short, medium and long term.

In 2013/14 we completed a stocktake of triage protocols and clinical prioritisation tools in use in elective surgical services to identify opportunities for regional alignment and service improvement activity in 2014/15. We have started to collect a major trauma data set aligned with the New Zealand Major Trauma Minimum Dataset and have started to modify our Trauma Registry to align with these requirements. All Northern regional DHBs have a Clinical Trauma lead.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Reduce waiting times for assessment, diagnostic and treatment services to achieve maximum waiting times of four months by 31 December 2014 by:
  ○ Adopting regionally consistent clinical prioritisation tools and clinical thresholds within the Auckland region with support from the other regional DHBs as available by service – on-going
  ○ Ensuring patients are treated in accordance with their assigned priority and time waiting – on-going
  ○ Delivering elective services according to agreed levels of access for the Auckland DHB population and other DHB populations - on-going
  ○ Increasing internal DHB surgical capacity through more efficient use of operating rooms – analysis of theatre utilisation and development of efficiency plan to be implemented from September 2014
• Work with national clinical groups to
	• Meet the health target by delivering a minimum of 13,872 elective discharges by 30 June 2015
	• Volume of discharges delivered for other DHB populations is in line with funding agreements
	• Compliance with four month wait time for FSA and elective surgery by 31 December 2014
	• 90% of accepted referrals for CT scans, and 80% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)
	• Dedicated outpatients MRI at Greenlane Clinical Centre (GCC) will be operational in November 2014 and outpatient CT scanner at GCC will be operational August 2014.
	• National Patient Flow data – phase 1 - able to be reported from 1 July 2014
	• National Patient Flow data – phase 2 - able to be reported from 1 July 2015
	• Provision of 50% of the fields required of the New Zealand Major Trauma Dataset by

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
contribute to service excellence projects in both Computer Tomography (CT) and Magnetic Resonance Imaging (MRI) looking at improved access and waiting times: ***Computer Tomography (CT)*** ○ Regular auditing of waitlist and priority codes – on-going ○ Weekly capacity planning for four week schedule – on-going ○ Implementation of outpatient CT service at Greenlane Radiology by August 2014 ○ Improvement of work flow project level 5 CT scanners at Auckland City Hospital Initial phase completed April 2014, new phase commencing August 2014 due completion November 2014. ***Magnetic Resonance Imaging (MRI)*** ○ Regular feedback to referring clinicians on referrals patterns and volumes – on-going ○ Regular auditing of waitlist and priority codes – on-going ○ Weekly capacity planning for four week schedule – on-going ○ Regular monitoring of outsourced volumes – on-going ○ Implement outpatient MRI service at Greenlane Radiology by November 2014. • Allocate additional funding to increase the number of elective discharges by 373 by June 2015 • Investigate why the Auckland DHB rate of joint interventions is lower than the rest of the country and identify any actions needed to address the lower rates by September 2014 • Develop and test a methodology for measuring access to elective surgery by ethnicity, accounting for need for intervention and other demographic factors by 30 June 2015 • Work with other DHB clinical service groups and/or primary care providers to establish at least two alternative pathways of care for common musculoskeletal problems by 30 September 2014 • Work with clinicians to identify opportunities to radically review and redesign the way outpatient ophthalmology services are	1 December 2014 • Report on the full New Zealand Major Trauma Minimum Dataset by 1 July 2015. *Note: regional imperatives will be met from current budget; no additional budget allocations will be made*

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

provided and develop a systematic plan to implement alternative service delivery models by September 2014
• Ensure that there is active participation by Auckland DHB surgical clinical leaders in the on-going development and implementation of the electronic referral system from July 2014
• Set up systems to capture and report data for the new National Patient Flow system:
  ○ Phase 1: set up/revise new outcome codes for outpatients and clinic processes, train all doctors and clinic schedulers on new requirements to ensure reporting capability from 1 July 2014
  ○ Phase 2: capture of data including diagnostic testing and treatment information, ensuring reporting capability from 1 July 2015.
• Implement agreed priorities established within the Regional Service Plan relating to major trauma services by 30 June 2015
• Modify our Trauma Registry to align with the New Zealand Major Trauma Minimum Dataset by January 2015
• Work with regional and national clinical groups to contribute to the development of improvement programme for diagnostics
• Maintain six CTA funded sonographer training positions during 2014/15
• Pending board approval, a third MRI facility will be up and running on the Greenlane site by October 2014.	

Shorter Waits for Cancer Treatment (Faster Cancer Treatment)

What are we trying to do?

Auckland DHB will provide timely and highly effective access to cancer treatment services and better co-ordinated care, while exceeding the health target, so no patients wait more than four weeks for radiotherapy or chemotherapy to sustain people's health and independence for as long as possible. We are also committed to supporting the successful implementation of the national bowel screening pilot.

Why is this important for community and patients?

Cancer is the second leading cause of death in our district - approximately 729 people die in Auckland per year from cancer. Despite significant improvement in recent years, some of our patients still wait too long for their cancer diagnosis and treatment, and some struggle to navigate their way through our health services.

Progress to date

Auckland DHB's cancer mortality rate is 119 per 100,000 population (126/100,000 nationally)[3]. None of our patients wait more than four weeks for radiotherapy or chemotherapy. There are no inequalities for Māori or others in these waiting times. We are also improving the waiting time at every stage of the journey.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Continue to monitor performance against the radiotherapy and chemotherapy waiting times health target – on-going
• Undertake several service improvement activities including: increasing day stay utilisation; improving FSA timeliness; utilising nurse specialists differently; introducing the radiation therapy planning tool and developing new internal targets. Specifics of the activity will be identified and implemented by 30 June 2015
• Establish a five year colonoscopy capacity plan that includes a regional view of colonoscopy capacity by 31 December 2014
• Implement a nurse endoscopist training programme regionally by 30 September 2014
• Auckland DHB's endoscopy service will participate in the National Endoscopy Quality Improvement Programme and action any improvement required during the year
• Improve the timeliness and quality of the cancer patient pathway from the time
	• Continued compliance with the faster cancer treatment target of maximum four weeks waiting time for radiotherapy and chemotherapy (*becomes part of indicator reporting from October 2014 – no longer a health target)*
	• Faster Cancer Treatment indicators routinely measured and reported quarterly; including by ethnic group
	  ○ All patients with a confirmed diagnosis of cancer receive their first cancer treatment within 31 days of decision to treat
	  ○ 85% patients referred urgently with a high suspicion of cancer receive their first cancer treatment within 62 days *(becomes a health target from October 2014)*
	• 75% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks (14 days)
	• 60% of people accepted for a diagnostic colonoscopy receive their procedure within

[3] 2010 age standardised rates (mortality data)

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
patients are referred into our DHBs through their treatment to follow up /palliative care – develop a monthly report which will assist in identifying how long patients wait from referral to treatment by June 2015 • Combine medical oncology and radiation oncology clinics by December 2014 • Identify and implement improvements to the quality of faster cancer treatment indicator data, including collection by ethnicity • Develop action plans to address ethnic differences in access for our population by 31 December 2014 and take steps to implement improvements by 30 June 2015 within available resources • Develop multidisciplinary meetings (MDM) to be highly functional both locally and regionally, including multidisciplinary video conferencing meetings. Tumour stream templates will be used live in cancer MDM meetings from July 2014 • Provide quarterly reports on the faster cancer treatment indicators and targets by tumour stream and collect ethnicity data for these from July 2014 • Review our compliance with three additional tumour standards including the breast tumour standards in 2014/15 and identify service improvement activity by 30 June 2015 • Actively participate in the regional prostate, bowel and lung tumour group activities facilitated by the Northern Cancer Network (NCN) • Fund staff inputs to the Bowel Screening Pilot (Waitemata DHB) Steering Committee and the Kaitiaki Roopu group as well as provide associated laboratory services and quality input – on-going • Ensure cancer care coordinators and our nurses participate in regional and national training opportunities on going and evaluate the cancer care coordinator roles by June 2015 • Open our new Bone Marrow Transplant Unit in July 2014.	six weeks (42 days) • 60% of people waiting for a surveillance colonoscopy wait no longer than twelve weeks (84 days) beyond the planned date • Progress delivering improved functionality and coverage of high-quality cancer MDMs (PP24). • Cervical screening rates increase to 80% coverage especially for Māori and Pacific women • Auckland DHB will re-establish a Cancer Control Steering Group which will meet three times per annum with the Waitemata DHB Cancer Control Group. *Note: regional imperatives will be met from current budget, no additional budget allocations will be made.*

Increased Immunisation

What are we trying to do?

Auckland DHB will achieve the immunisation health target – 95% of children fully immunised at 8 months (by 31 December 2014), and maintain this.

Why is this important for community and patients?

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease and consequently better health and independence for children. This equates to longer and healthier lives. The changes which are required to reach the target immunisation coverage levels will lead to better health services for children because more children will be enrolled with and visit their primary care provider on a regular basis. It will also require primary and hospital health services for children to be better co-ordinated. The primary care workforce including maternity is better equipped to address the needs of children and families.

Progress to date

94% of Auckland children were fully immunised at 8 months at the end of December 2013 and major progress has been made in reducing the inequality gap with an increase of 14% for Māori and 6% for Pacific since 2012. Auckland and Waitemata DHBs commenced an integrated National Immunisation Register(NIR)/Outreach Immunisation Service for the two districts. Services are delivered by a non-governmental organisation (NGO) working with primary health care organisations (PHOs) and other primary care partners.

Starship Emergency Department check the immunisation status of presenting children less than 5 years of age. Overdue children are offered immunisation or referred for follow-up. The process of handover of mother and child as they move through maternity and primary care services has been described. A pathway has been established for rapid referral to outreach and primary care for Māori newborns with no GP.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Work with NIR, primary care partners and the Māori health team to develop a 6 month Milestone Project to improve timeliness of 3 and 5 month immunisation events to reduce the equity gap for Māori tamariki, by September 2014 • Develop and distribute recommendations for improving early enrolment processes by April 2015 • Embed process to improve handover of mother and child through maternity, primary care and Well Child/Tamariki Ora (WCTO) services • Monitor monthly DHB, PHO and practice level coverage reports and manage service delivery gaps – on-going • Develop systematic early indicators of changes in practice performance by September 2014. Practices identified will be given additional support by PHOs and NIR	• 95% of 8 month old children are fully immunised by December 2014 and maintained • 88% of newborn children are enrolled with a GP by three months by December 2014 and 98% by June 2016 • 85% of 6 week immunisations are completed by December 2014 and maintained • 95% of 2 year immunisations are completed and maintained • 70% of Māori 6 month old children are fully immunised by December 2014 • Report on DHB and interagency activities to promote immunisation week 2015 completed by February 2015.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Commence an immunisation coordination service model across Auckland and Waitemata DHBs by July 2015 • Implement the 2014 Immunisation Schedule changes from July 2014 • Continue to present immunisation issues, updates and plan local promotion activities at the bi-monthly Child Health Stakeholder Advisory Group (CHSAG with representatives from Health, Education and Social Services. • Work collaboratively with NGOs and government agencies across the sector to increase immunisation coverage • Strengthen primary health care participation in the Auckland and Waitemata DHB combined immunisation steering and operational groups.	

Better Help for Smokers to Quit

What are we trying to do?

Auckland DHB wants to support smokers to quit by achieving the following health targets:

- 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals
- 90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking
- 90% of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with lead maternity carer are offered advice and support to quit.

We also want to reduce smoking prevalence thereby assisting the country in achieving Smokefree Aotearoa 2025.

Why is this important for community and patients?

Smoking is the most significant cause of premature and preventable death in New Zealand. The prevalence of smoking in Auckland DHB was 11.2% according to census 2013 (total response). Māori and Pacific people are more likely to smoke (26.3% and 21.9% respectively) and these population groups, along with pregnant women and those with mental health problems are more likely to experience negative health impacts.

Progress to date

Our smoking prevalence is one of the lowest in the country at 11.2% and we have achieved the better help for hospitalised smokers to quit health target consistently over the last year. We have also seen significant increases in the percentage of smokers offered advice to quit in primary care – from 37% December 2012 to 61% December 2013.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Initiatives led by hospital care • The Smokefree Services Team will continue to monitor and audit performance against the health target and provide targeted support to services that are below 90% - on-going • Follow up Māori and Pacific people seeking post discharge support to quit smoking will be followed up to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs - follow up support process in place by December 2014 • Maintain a centralised triage and referral system for smokers identified in hospital care for on-going support in the community – on-going • The Smokefree Services Team will provide charge nurses with resources and – on-going support in each inpatient hospital service (84 services) so they can provide training and support to their clinical staff in order to maintain the brief advice and cessation support approach – on-going. ***Initiatives led by primary care*** Allocate $210k to primary care activity specifically aimed at meeting the health target: • The DHB will contract with each PHO to have a Smokefree Coordinator that will lead a smokefree plan and activities for that PHO – by October 2014 • PHOs will ensure GPs and nurses are trained and supported to ask patients about smoking, offer advice and referrals for support to quit and that these interventions are documented – on-going • PHOs will support practices to have software in place to prompt providing advice to quit and robust data management systems for documentation – on-going • Each PHO will have a clinical champion and provide quarterly feedback to each GP/practice on their relative performance on meeting the health target by September 2014 • Each PHO will provide support to practices that miss providing advice and support to quit to patients when they visit the practice – on-going. ***Initiatives led by planning & funding*** • Update the DHB's Tobacco Control Plan by December 2014 • Identify and support Māori leaders e.g. 'Aunties'	• 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking • 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking by June 2015 • 90% of Māori seeking post discharge support to quit smoking followed up to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs • 90% of GPs and Practice Nurses trained in brief advice and cessation support • 10 Māori leaders are identified as community champions by December 2014 • 90% of pregnant women who are smokers at the time of booking with a LMC are offered advice and support to quit. *Note: it is expected that these targets will be equitably met for Māori and Pacific people.*

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
to champion and promote quitting in their communities – implement trial in quarter two of 2014/15 • Facilitate smokefree training for community based health professionals – on-going • Collaborate with and support Auckland Council and the Cancer Society on implementing the new smokefree public places policies, commenced by September 2014 • Champion the Ministry of Health Innovation Fund projects (Quit Bus, WINZ training, Hospital Visitors) that are taking place within Auckland DHB. ***Maternity specific*** • Monitor and provide feedback to Lead Maternity Carers on their individual maternity health target result by December 2014 • Work with Midwives, Specialist Smokefree Services and Maori Health to collaboratively develop information to be given to women at confirmation of pregnancy to encourage quitting smoking – on-going • Auckland DHB Smokefree will include updates on smoking cessation in pregnancy via a quarterly newsletter to all Lead Maternity Carers associated with National Women's Health, attendance at monthly Auckland DHB Community Midwives meetings, and quarterly team promotion days held at National Women's Health • Work with the local Clinical Link Champion to ensure midwives give consistent messages and referrals to quit smoking services to their clients by December 2014.	

More Heart and Diabetes Checks & Long Term Conditions (including Diabetes)

What are we trying to do?

We will meet the health target – 90% of the eligible population will have had their cardiovascular risk assessed in the last five years. We also want to improve outcomes for those with cardiovascular disease and diabetes and other long term conditions. We focus services to ensure Māori and Pacific people in particular obtain early diagnosis and effective management of cardiovascular and diabetes risk and other long term conditions.

Why is this important for community and patients?

Despite the declining mortality rates in recent years, cardiovascular disease remains the leading cause of death in Auckland causing 786 deaths per year. The disease burden for people is

exacerbated and compounded by diabetes - the incidence of which is increasing markedly as a consequence of rising obesity. Over 23,649 Auckland DHB residents live with diabetes, 153,350 people are eligible for a five year risk assessment.

Progress to date

Our cardiovascular mortality rate (116 per 100,000) is amongst the lowest in the country. Our diabetes prevalence is similar to the national average of 4.4% according to the 2011/12 New Zealand Health Survey. Nearly 128,000 people in the Auckland district had received a heart and diabetes check by December 2013 (83.3% coverage). Coverage for Māori has improved 27% over the past year and 18% for Pacific and we are pleased that this makes us the leading DHB in New Zealand for these two groups. Also, 69% of the eligible population of Auckland DHB have completed their annual diabetes review and of these, 62% have good diabetes management. 71% of people who have had a diabetes annual review had an HbA1c of ≤ 64mmol/mol.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Prevention • Provide an opportunity for 6,062 people to participate in the Green Prescription programme over the year • Provide 10,800 retinal screening visits for people with diabetes over the year • Provide 1,931 packages of care for people with diabetes and high risk foot disease over the year. ***Identification*** • Ensure 90% of the eligible population have their cardiovascular and diabetes risk assessment completed every five years through PHO and general practice service agreements and activities – on-going • Work collaboratively with PHOs to develop plans to meet the health target by 1 Sept 2014. ***Management*** • Deliver the Diabetes Care Improvement Package (DCIP) through PHOs and general practice to improve the care of people with diabetes – on-going • Continue annual diabetes checks, including a cardiovascular assessment and care plan with the patient for the next year – on-going • Engage with the DHB/PHO Alliance to ensure any services for long term conditions are linked to existing strategies eg CarePlus, DCIP and the PHO performance programme. ***Enablers*** • Work directly with the Northern Region Cardiac Network and PHOs, using quarterly regional reports as basis for discussion with the PHOs regarding medical adherence for people with	• 10,800 retinal screening visits provided for people with diabetes by the end of the year • 90% target for more heart and diabetes checks reached and maintained - quarterly • 75% of people who have had a diabetes annual review have a HbA1c of ≤ 64mmol/mol by 30 June 2015, monitored quarterly • Percentage of people with cardiovascular disease on triple therapy as reported by the Northern Region Cardiac Network maintained (or improved) at June 2014. (12 months rolling report) • Final agreed indicators presented to the primary care Clinical Governance group no later than 30 June 2015 • Quarterly performance reports from providers delivering services through DHB contracts. Reports include total population and ethnicity information.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

CVD – on-going
• Work with the Alliance and regional networks to identify key indicators for the management of diabetes and cardiovascular risk by 30 December 2014
• Work with existing services (eg Te Hononga Whānau disease specific primary care nurses) to maximise resources and outcomes for Māori and Pacific people – on-going
• Implement consistent and sustainable services to maintain health target achievement including (all on-going):
  ○ Continuing clinician education
  ○ Practice audit tools and dashboards to ensure effective assessment and management of people
  ○ Use of PHO practice liaison staff to manage quality and service plans with low performing practices
  ○ Virtual CVD risk assessments
  ○ Regional collaboration for workplace CVD assessments.
• Assess the outcome of the west Auckland locality integrated diabetes service pilot evaluation to determine how to implement integrated diabetes services within the Auckland DHB region/district – implementation priorities identified by June 2015
• Quality improvement services will work in conjunction with PHO liaison staff to improve care within practices - monitored quarterly.	

Better Public Services

Reducing Rheumatic Fever

What are we trying to do?

We will reduce the incidence of rheumatic fever by a further 20% to 1.9 per 100,000 of population.

Why is this important for community and patients?

Rheumatic fever is a preventable disease. Reducing the incidence of acute rheumatic fever will reduce the burden of disease experienced by patients and their families and reduce the morbidity and mortality and the associated costs to the health service.

Progress to date

Auckland DHB acute rheumatic fever baseline 3 year rate was 3.5/100,000 of population (16 cases) as at 2011/12. We have made significant progress implementing rheumatic fever responses during 2013/14, including training health professionals and putting systems in place to obtain monitoring data to support on-going analysis. We have also undertaken reviews of all cases of acute rheumatic fever.

We have established 16 school-based throat swabbing and management programmes in the district and identified 15 general practices with the highest enrolled target populations as the initial open access rapid response clinics. We are developing referral processes to the Auckland-wide Healthy Homes Initiative (AWHI) for the school-based programme, bicillin (penicillin) service and hospital care. We are developing and implementing a strong community awareness raising campaign, launched at Ruapotaka Marae with the Hon Tony Ryall, Minister of Health.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
In addition to all the commitments made in our rapid response and rheumatic fever programme plans, activities during 2014/15 will be adopted and modified in response to results from full implementation of the programme: • Respond to information from the school based swabbing programme and tailor services more appropriately if required regarding: frequency of swabbing, follow up with families, health literacy information, access to after-hours services and rapid response general practice (GP) and community based clinics • Continue to educate health professionals regarding guidelines and where possible, monitoring adherence to guidelines – on-going • Further promoting awareness of rheumatic fever prevention and treatment options through work with the Ministries of Health and Youth Development focused on youth and by engaging with providers from other sectors working with the rheumatic fever target population over 2014/15	• A further 20% reduction on the Auckland DHB 2013/2014 target rate of 3.5 per 100,000 to 1.9 per 100,000 population (n=9) • 100% of all new cases of rheumatic fever are reviewed, with a focus on learnings that inform future practice regarding the management of sore throats prior to hospitalisation with acute rheumatic fever.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Monitor whether communications are achieving appropriate responses from target communities over 2014/15 • Develop systems and processes and provide on-going training to a range of staff to support referrals to the AWHI programme from hospital care, the bicillin service and school based sore throat management programme • Undertake systematic case reviews and root cause analysis for every case of acute rheumatic fever in the district.	

Prime Minister's Youth Mental Health Project

What are we trying to do?

Auckland DHB is working to increase resilience and improve outcomes particularly for Māori and Pacific young people, by intervening early, decreasing waiting times and increasing access to services. We are developing youth friendly service delivery models/workforce with expanded access to integrated mental health and alcohol and drug services, across primary and hospital care, non-government organisations (NGOs) and schools, using a Stepped Care model.

Why is this important for community and patients?

Mental health and alcohol and drug issues in young people have low rates of recognition. Barriers include lack of awareness and reluctance to seek help through conventional health services. The lack of early intervention increases the risk of on-going adult mental health and addiction problems. Young people are also a high risk group for suicide and Māori and Pacific young people are at comparatively higher risk of mental health issues.

The expansion of access to primary mental health services alleviates the distress, suffering and longer-term poor outcomes for those young people and their families who are not currently eligible for interventions for mild to moderate conditions. It also supports expectations in the Service Development Plan, the Prime Minister's Youth Mental Health Project and Drivers of Crime priority areas in relation to alcohol related crime committed by young people.

Progress to date

Nearly 9,000 young people in Auckland have increased access to primary health services through the school-based health service programme (SBHS). Through these services, 1,610 or 96% of Year 9 students in the mainstream programme received a comprehensive wellness check (HEEADSSS) in 2013, with an additional 124 'high risk' young people attending a main-stream secondary school receiving the check.

Comprehensive nurse-led services are funded by Auckland DHB and 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; have undertaken HEEADSSS[4] training and have been actively participating in up-

[4] Home, Education/Employment Eating, Activities, Drugs, Sexuality, Suicide and Depression and Safety

skilling in primary mental health. The Auckland Youth Health Services Alliance was signed in August 2013 between the DHB and four PHOs. A general practitioner (GP) lead for youth health has been appointed under this Alliance. A Youth Health Clinical Governance Group has also been established.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• More 'high risk' students will receive a HEEADSSS assessment and are supported to access appropriate services during 2014/15 • Through the Youth Health Alliance build GP capability in mental health and ensure GP providers in the enhanced schools programme receive 'Comprehensive Wellness Check (HEEADSSS)' training and extend use of this tool into their general practice in 2014/15 • Implementation of the CAPA (Choice and Partnership approach) style approach will be completed by December 2014 and will improve waiting times for non-urgent mental health and addiction services for young people • Young people in alternative education settings will continue to receive counselling through Youthline – on-going • Ensure a range of psychological services are available to young people, including e-therapy (once determined by the Ministry of Health) – to be implemented in 2014/15 • Implement targeted actions identified by the stock take gap analysis in conjunction with relevant stakeholders over 2014/15 • All 'high risk' young pregnant women identified during 2014/15 are referred to and can access youth appropriate primary mental health services • GP practices associated with the schools programmes are supported to provide more appropriate youth health services through the development of standards and training in youth health • Assess whether the SBHS programme is improving equity by June 2015 • Provide validated mental health screening tools for school nurses and school counsellors to ensure consistent care and referral pathways by April 2014 • Through the Youth Health Alliance pilot a visiting psychologist in school service by April 2015 • Work with partner schools to encourage a multidisciplinary team approach with nurses, GPs and school counsellors to provide	• Collect percentage of youth aged 12 to 19 discharged from the Child and Adolescent Mental Health Service (CAMHS) and youth alcohol and drug (AOD) services into primary care being provided with follow-up care plans • Meet the waiting time targets for non-urgent mental health and addiction services – 80% seen within 3 weeks, 95% within 8 weeks (including child and adolescent mental health services and youth alcohol and drug services) • Meet youth access rates (0-18 years) to specialist drug and alcohol services target of 1.5% by June 2015 (regional target) • At least 120 high risk students will receive HEEADSSS assessments in 2014/15.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
integrated care – on-going • Work more collaboratively with other agencies, particularly Child, Youth and Family Services (CYFS) and Youth Justice, who are providing services to 'at risk' young people by December 2014 • Implement the 2014/15 actions from the Auckland DHB Child and Youth Mental Health and Addictions Direction (2013 to 2023) with interagency partners, focusing on early intervention and prevention by June 2015 • Provision of follow-up care plans for youth aged 12 to 19 discharged from hospital care into primary care. This will be rolled out when the guidelines are released by MOH and the Werry Centre. Expected to be released by December 2014 • Services further developed for children of parents with mental illness and addictions – 2 pilots in place by December 2014.	

Children's Action Plan Implementation

What are we trying to do?

Auckland DHB wants to reduce the number of childhood assaults and support the prevention and early identification of child maltreatment through delivering on the Children's Action Plan (CAP) and aligned initiatives. We also want to provide services which contribute to infants having the highest attainable standard of health and equity of life expectancy and parents being confident, knowledgeable and supported to nurture.

Why is this important for community and patients?

By working together with communities, community providers, primary health care partners, maternity and midwifery teams, and specialist and hospital health care services we will help improve outcomes for vulnerable children and contribute to a reduction in the number of child assaults.

Progress to date

We are a signatory to the Memorandum of Understanding (MoU) with Child, Youth and Family Services (CYFS), police and DHBs and we host CYFS funded liaison social workers. We have implemented the National Child Protection Alert System (NCPAS).

We have policies and reporting systems in place to recognise and report child abuse and neglect along with Ministry of Health accredited training programmes to support staff to recognise and respond to family violence and child protection issues. We have a multidisciplinary Vulnerable Pregnant Women's Group - Wahine Ora – and we are the national centre of excellence in clinical multi-disciplinary child protection practice (Te Puaruruhau). We have established and maintain the first multi-agency child protection centre where health staff are co-located with police and CYFS (Puawaitahi).

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 co-ordinator. The National Maternity Monitoring Group Annual Report 2013 highlighted National Women's as a good example of promoting maternal mental health.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Maintain and monitor the effectiveness of NCPAS and local patient information management system's (PIMs) alert system and take action to address any unintended negative consequences - on-going • Implement mental health initiatives including respite beds and support packages for women with maternal mental health issues by June 2015 • Establish and deliver a range of services for pregnant women and young families from the Whānau Ora centre in Glen Innes by June 2015 • Establish a baseline of women with maternal mental health issues utilising primary mental health services by April 2015 • Obtain information from and consider district wide implications associated with Children's Teams demonstration sites over 2014/15 • Ensure that staffing policies and procedures and contracts entered into align with the Vulnerable Children's Act once passed into law (in June 2014) • Establish multi-disciplinary Children's Teams, as and when appropriate • Implement relevant responses to Rising to the Challenge (eg. COPMIA), and Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand – on-going • Explore options for regional collaboration including governance with Counties Manukau and Waitemata DHBs through the Child Health Stakeholder Advisory Group (CHSAG) by June 2015. CHSAG includes social sector partner agencies including Child, Youth and Family (CYF), the Ministry of Education, Council, Plunket and PHOs • Identify and implement specific actions to increase referrals to the Gateway Assessment Programme by December 2014 • Encourage the establishment of Family Violence Prevention champions in Child Health, Women's Health, ED and Mental	• The rate of women who are screened for family violence and receive appropriate follow up increases from the current audited rate of 38% in Children's Health and 34% in Women's Health. • Report on the number, ethnicity and issues raised of women referred to vulnerable families groups • At least 20 (non DHB) LMCs are supported to provide better care to vulnerable pregnant women through the vulnerable pregnant women's group structure • 90% of children requiring a Gateway assessment are referred to the Gateway Assessment Programme • Achieve a minimum audit score of at least 70/100 for each of the child and partner abuse components of our VIP programme • At least 100 vulnerable pregnant women are referred to and receiving WCTO services during their pregnancy • 100% of staff in the following services are trained to recognise and respond to family violence: child health services, women's health services and sexual health services.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Health Services in 2014/15 • Ensure that support structures available to midwives through the Vulnerable Pregnant Women's Group are extended to and used by lead maternity carers (LMCs) providing care to vulnerable pregnant women over 2014/15 • Ensure vulnerable pregnant women are offered antenatal WCTO and Family Start programme as well as other supports over 2014/15 • Monitor the number of babies under Maternity Services that are taken into the care of Child, Youth and Family Services over 2014/15.	

Whānau Ora

What are we trying to do?

Auckland DHB will support 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 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 families.

Why is this important for community and patients?

There is a gap of 7 years in life expectancy between Māori and non- Māori. There is substantial scope to improve health gain for Māori and we know working with whānau to improve health and wellbeing is important to our Māori community and patients. By working with whānau we can mitigate risk factors that negatively impact on health and wellbeing, better manage existing conditions and improve health outcomes for patients. Working with whānau is responsive to Māori and aligned to tikanga best practice. This requires changes throughout the organisation, including at the highest level, to adopt a whānau focus aligned to Whānau Ora.

Progress to date

A Whānau Ora assessment tool has been implemented at Auckland City Hospital and a draft Whānau Ora Policy developed. We provided support to the Whānau Ora Collectives in their bid for the North Island non-government organisation (NGO) Whānau Ora Commissioning Agency.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Work with the Whānau Ora Collectives to integrate their health contracts, including multi-year contracts) by October 2014 • Engage MoU partners and wider Māori communities in the development of a Whānau Ora Outcomes Framework - agree on method, milestones and timelines) by June 2015	• A localised approach to Whānau Ora by Auckland DHB and MoU partner approved by Auckland DHB Board by June 2015 • Integrated contracts in place by December 2014 • Whānau Ora outcomes framework developed by June 2015.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Identify, in partnership with Whānau Ora providers key outcomes sought from formative/ process evaluation) by December 2014.	

System Integration

Cardiac and Stroke Services – including Acute Coronary Syndrome and Secondary Cardiac Services

What are we trying to do?

We want to achieve clinically appropriate, timely and equitable levels of access across the region to key cardiac and stroke assessment and treatment services in order to reduce disease and premature death in our community caused by cardiac disease and stroke.

Why is this important for community and patients?

Cardiac disease is a leading 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 treatment in the northern region. We need to continue to ensure there are equal outcomes for all members of our community, specifically Māori and Pacific people. We need to ensure we are consistently providing services to all members of our community within clinically acceptable waiting times.

The impact of stroke and trans ischemic attack (TIA) can be catastrophic for the individual and family and is resource intensive for health services. Managing these events according to the New Zealand Stroke Management Guidelines (2012) is essential for improving and maximising health outcomes for people after a stroke, or who are at risk of stroke.

Progress to date

Cardiac

Auckland DHB has one of the lowest CVD mortality rates in the country at 116 per 100,000. We have a stroke mortality rate of 21.1 per 100,000 which is about average compared to New Zealand as a whole. The percentage of eligible stroke patients' thrombolysed is 12%, twice the national target of 6%.

Cardiac surgery targets have been achieved including cardiac surgical intervention rates, which we have sustained for cardiac surgery, percutaneous revascularisation and coronary angiography. 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 four operating theatres (increased from 3), one additional Cardiac ICU bed and two ward beds to increase productivity and so reduce outsourcing.

We have completed clinical guidelines for treating out-of-hours ST segment elevation myocardial infarction (STEMI). We have established a local lead for supporting the implementation of the acute coronary syndrome pathway and information tool. An agreed regional electrophysiology service (EP) model of care has been developed and regional reporting is underway and has shown improvements in waiting time targets.

Stroke

80% of stroke patients were admitted to a dedicated stroke unit in the last 12 months. There are clear pathways for managing suspected stroke and TIA patients who present at the emergency department or are referred from primary care. 80% of TIA patients referred to the 'TIA clinic' were seen within 72 hours of receipt of referral.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Overall • Improve access to diagnostics by investigating current delays and developing action plans to be implemented by July 2014 • Identify initiatives to address the causes of ethnic differences in outcomes of cardiovascular disease for Māori and Pacific identified in the work completed in 2013/14 with a specific action plan by February 2015. ***Cardiac*** • Work with the regional and national cardiac networks to improve outcomes for acute coronary syndrome (ACS) including clinical pathway compliance review, reviewed by Northern Region Clinical Cardiac Network quarterly • Implement regionally agreed protocols for prompt local risk stratification by Dec 2014 • Support and participate in regional cardiac data reporting and monitoring of key cardiology indicators quarterly • Collect all indicator data by ethnicity to help identify and address gaps in equity reported quarterly as KPIs by Northern Region Cardiac Network by July 2014 • Ensure consistency of clinical prioritisation for cardiac surgery patients by achieving consistency of data used in the national cardiac clinical priority access criteria (CPAC) tool. Patients treated according to assigned priority and time waiting. Cardiac surgery patients operated on within nationally agreed urgency timeframes – on-going • Continue to manage the cardiac surgery waiting list in line with expectation - ongoing • We will review and strengthen the cardiac rehabilitation programme to engage appropriately with Māori, Pacific and high risk groups and explore options for community locations in collaboration with our DHB and primary care / NGO partners where inequalities are identified by July 2014.	• No patient will wait longer than 4 months for their first specialist appointment or treatment by December 2014 • 100% of inpatients waiting for acute cardiac surgery will receive surgery within 10 days of date of wait listing • Standardised intervention rates achieved per 10,000 of population: cardiac surgery – 6.5, percutaneous revascularisation – 12.5, coronary angiography – 34.7 • Patients requiring elective cardiac surgery will wait no more than 90 days for surgery • 100% outpatients appropriately referred will receive echocardiogram within 150 days of referral • 80% of all outpatients triaged to chest pain clinics will be seen within 6 weeks for cardiology assessment and stress test • 90% of outpatient coronary angiograms will be done within 90 days • >70% of high risk ACS patients will be accepted for coronary angiography and receive it within 3 days of admission (day of admission being day 0) • >95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and catheterisation and/or percutaneous coronary intervention (Cath/PCI) registry data collection reported quarterly • 80% of patients presenting with ST elevation myocardial infarction and referred for PCI will be treated within 120 minutes from time of triage • 95% of referred patients will receive EP service within 4 months by 30th June 2015 • 45% of eligible Māori, Pacific and Asian patients requiring cardiac rehabilitation will complete a cardiac rehabilitation programme • 12% of potentially eligible stroke patients are thrombolysed • 100% of patients with stroke have a CT or MRI within 24 hours • 80% of stroke patients are admitted to the stroke unit and all are managed according to the

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Stroke • Improve collection for both stroke and TIA data – on-going • Support the training and up-skilling of primary care using the stroke and TIA - age, blood pressure, clinical features and duration of TIA (ABCD) tool by February 2015 • In partnership with primary care and with key stakeholders, streamline the referral and care pathway processes as linked to the regional programme milestones by February 2015 • Continue MDT workforce training to support care pathways as per the NZ Stroke Guidelines – on-going.	New Zealand Stroke Guidelines. *Note: regional imperatives will be met from current budget, no additional budget allocations will be made.*

Primary Care

What are we trying to do?

We want to develop a high quality and sustainable primary and community health system. We will therefore increase the integration of community, primary and hospital care health services. We support earlier identification and better management of long term conditions, build capability and capacity by increasing the scope of primary care and support infrastructure development enabling us to drive performance through quality improvement and transparent reporting.

Why is this important for community and patients?

Primary care is central to improving health and reducing inequalities. 90 percent of our population's interactions with the health system occur in primary care. Mostly these interactions are positive, but there is more that can be done to integrate services, improve the management of long term conditions and increase the involvement of patients, families and whānau in their care.

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.

Progress to date

We have continued to improve the relationships between the DHBs and primary health care. The Auckland and Waitemata District Alliance is in place with a focus on patient and whanau determined care, improved integration, long term conditions and building capability and capacity in primary care. The Alliance Leadership Team (ALT) will be in place by 30 June 2014. We have established the Tamaki locality which has mental health as the priority. Clinically led (primary and hospital) new models of care have been developed including:

- Cognitive impairment pathway
- Mental health integrated Stepped Care model

A new National Immunisation Register and Outreach Immunisation Services are in place. All After Hours Network practices are free to all under six year olds. Primary care funding arrangements for Great Barrier Island have been reviewed and amended. A Youth Service Level Alliance has been

formed and Rheumatic Fever Programmes have been developed and implemented with Māori, Pacific and primary care providers.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Scope and develop Tamaki locality – mental health model of care by 1 April 2015
• The Alliance Leadership Team (ALT) will have an agreed work programme by 1 October 2014
• Rural service alliance team in place with agreed work plan by 1 October 2014
• Develop a plan for distribution of rural funding by June 2015 for implementation in 2015/16
• Integrated models of care and Mental health stepped care pilots complete with approved roll out plans by 30 June 2015
• Revised after-hours business model agreed and implemented by 30 June 2015
• Continue to provide primary care access to acute specialist advice for a range of services including paediatrics, renal, cardiology, general medicine and general surgery – on-going
• Maintain direct access for general practitioners to a full suite of diagnostic imaging including x-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI with a focus on managing to waiting times – on-going (budget = $500,000)
• Improve GP access to elective surgical lists through enabling specialists in the hospitals to respond directly to GPs about the appropriateness or not of their e-referrals and of any additional work up required, enabling faster surgery confirmation for the patient – on-going
• Work with PHOs and regional Primary Options for Acute Care (POAC) members to continue to support appropriate access to services across Auckland (Target=4,531 referrals by June 2015
• Work with PHOs to jointly implement the Integrated Performance and Incentive Framework (IPIF) from July 2014
• Continue projects to improve PHO enrolment and data accuracy especially among high need individuals, specifically:
  ○ Primary Care Ethnicity Data Audit Toolkit project – commenced July 2014
  ○ Newborn enrolment projects – three work streams – completed by June 2015
• Complete review of health services Waiheke Island by 31 March 2015
• Support the implementation of Phase 4 of the
	• All Health Targets achieved each and every quarter
	• Work programmes reporting through to the Auckland and Waitemata District Alliance and to the Metropolitan Auckland Clinical Governance and Leadership forum quarterly from September 2014
	• Patient and Whānau Determined Health programmes in place, June 2015
	• After Hours contract in place, June 2015
	• Integrated models of care: Stepped Care pilots evaluated, June 2015
	• 50% of IFHCs / GPs provide an after-hours summary to ED via the self-care portal by December 2014
	• 90% of the PHO eligible population have access to a self-care portal by December 2014
	• 10% of the PHO eligible population have accessed a self-care portal by December 2014.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Community Pharmacy Services Agreement through engaging primary care prescribers and hospital care services with pharmacy in accordance with nationally agreed timelines • Technology enablers such as e-shared care will continue to be deployed across the primary and hospital sector as the models of care are developed in localities throughout 2014/15. The system changes required to implement e-referrals have been completed and deployment across the hospital services will be complete by 2014. A regional role will encourage and support the uptake of e-referrals in primary care under the regional DHB/PHO Care Connect governance being established for 2014/15 • Review and revise the primary health care nursing strategy by December 2014 • DHBs and PHOs will support the availability of patient portals to PHO enrolled populations in 2014 • Support the availability of provider portals to enable health providers to access a primary care summary record in 2014 • Support emergency departments to be able to access a primary care summary record in 2014.	

Health of Older People

What are we trying to do?

We want to improve outcomes for older people and maximise years of life and quality of life. In order to do this we want to:

- Support and enable older people to participate to their fullest ability in decisions about their health and well-being
- Streamline access for them to all aspects of health services ensuring a 'right place, right time' experience
- Support them to stay at home when it is safe and cost effective thereby reducing the requirement for Aged Related Residential Care (ARRC) placement
- Provide care that maximises independence
- Develop integrated services to avoid hospital readmissions

Why is this important for community and patients?

Our 65+ population is increasing and is projected to be 15% of the total population by 2021, using a substantially greater proportion of our services than other age groups. Older people should receive coordinated and responsive health and disability services, ie 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. For those that require a hospital admission or other hospital or tertiary care, the services need to be responsive

and connected. We need to ensure these services are structured and provided to make the best use of health funding in order to meet increasing demands.

Progress to date

An Aged Related Residential Care (ARRC) interRAI (comprehensive clinical assessment) Provider Forum was established and over 95% of ARRC facilities are engaged in interRAI training. An ARRC model with host facilities has been established initially for collaborative management of falls and pressure injuries. The Specialist Health of Older People team are proactively supporting ARRC including quarterly study days for nurses and health care assistants. The 'yellow envelope' has been implemented to improve transfer of clinical information between acute care and ARRC.

Several work-streams have been initiated in order to enhance rapid response and better discharge management for older people - ED/APU based physiotherapist to assist with the provision of wrap around services, the Restorative Home and Community Support Service (HCSS) model has been implemented which includes prevention strategies and is highly responsive and flexible to clients' needs, enhancement of POAC pathways to ensure people can be treated in their aged residential care facilities wherever possible (eg. IV antibiotic therapy) and daily monitoring of ARRC admissions to the emergency department to ensure appropriateness).

Co-design methodology workshops have been completed for the Dementia Care Pathway and work streams have been established. Flexible funding packages for respite care have also been established. A gap analysis of services offered to older people on admission to the Emergency Department (ED) was undertaken to inform service development.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Support the national interRAI training programme within ARRC
  ○ Establish a regional Governance Group for interRAI
  ○ Facilitate bi-monthly ARRC provider InterRAI forums by July 2014
• Develop a system to analyse the interRAI data set for HCS
• Survey clients using core quality measures (once produced by DHB Shared Services and the Ministry of Health) to identify gaps in need for older people to inform the development of services that will support older people to stay well in their own homes
• Establish baseline data and benchmark our performance with other DHBs using core quality measures for HCSS (once produced by DHB Shared Services and the Ministry of Health)
• Use additional funding allocated through Budget 2013 for HCSS to increase support for high/ complex clients – on-going funding over 2014/15
• Analyse and understand the trends and triggers for admission to ARRC by December 2014
• Based on the review of HOP services undertaken in January 2014; plan and develop components of intermediate care by December 2014
	• All ARRC facilities are using InterRAI as the primary assessment tool by 30 June 2015
	• Baseline for HCSS core quality measures established and benchmark with other DHBs completed
	• The number of HCSS clients in the most complex category of the case mix are at or above the 2013 level (250)
	• Intermediate care pilots are underway by 30 June 2015
	• Restorative intermediate services:
	  ○ Work-plan approved by September 2014
	  ○ Implementation of pilots by June 2015
	• At least 1300 ARRC residents are case managed or provided with a consult and liaison by gerontology nurse specialists (baseline estimate 2013/14 – 1200)
	• At least 500 attendances by nurses and health care assistants from ARRC at health of older people specialist study days
	• The Dementia Care Pathway based on co-design methodology is implemented by 30 June 2015
	• The Fracture Liaison Service is operational; the number of people identified as having a fragility fracture and the number of people

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Based on the 2013/14 review of HOP services, establish a community based gerontology nurse specialist (GNS)/gerontologist in ED/APU to provide rapid response and support appropriate discharge through provision of wrap around services (community in-reach)
• Further develop proactive use of our Specialist Services for Older People (geriatricians, gerontology nurse specialists, nurse practitioners, pharmacist) to advise and support health professionals in primary care and ARRC – on-going
• Implement the Dementia Care Pathway:
  ○ Implement a standardised carer assessment form by December 2014
  ○ Complete training needs analysis by December 2014
  ○ Disseminate service directory by Dec 2014
  ○ Pilot and evaluate shared care record for dementia care by June 2015
  ○ Support implementation of the regional Cognitive Impairment Clinical Pathway in primary care by June 2015
• Deliver hospital preventative care for fragility sufferers (through identification, investigation and intervention) to prevent hip fractures by June 2015
• Develop an integrated falls prevention pathway by June 2015
• Implement the Kaumatua Action Plan developed during 2013/14 to improve the way in which services we purchase and provide engage with Māori patients and their whānau by June 2015
• Facilitate implementation of the Regional Health of Older People Plan at a district level through the regional Health of Older People (HOP) Forum and the HOP Clinical Network by 30 June 2015.
	receiving treatment for osteoporosis are recorded
	• 100% of older people receiving long-term home support will have a comprehensive clinical assessment and an individual care plan; 85% will have their reassessment within 12 months
	• Integrated fall prevention pathway is developed - June 2015
	• Three or more priority recommendations from the Kaumatua Action Plan are progressed
	• Targets in the Regional Health of Older People Plan are achieved.
	Note: regional imperatives will be met from current budget, no additional budget allocations will be made.

Mental Health (Service Development Plan)

What are we trying to do?

We want to improve outcomes for people affected by mental health issues. We will do this by providing early and effective best practice interventions, increasing access to integrated Mental Health and Alcohol and Drug (AOD) responses across the continuum (primary, hospital and tertiary care, and non-governmental organisation (NGO) services) to contribute to a reduction in suicides.

Why is this important for community and patients?

20% of the population have experienced some form of mental illness over the last year and 3% are severely affected by mental illness. Approximately 41 deaths in our district annually are as a result of suicide, with a disproportionate number being young Māori men.

People can build resilience if information, assessment or treatment is available when mental health or addiction problems emerge. Better mental health and addiction outcomes are achieved by: multi-agency responsiveness; increased access to services; addressing inequalities and ensuring different needs are met for the most complex problems. Delivering improved mental health services supports expectations in Blueprint II and Rising to the Challenge (Service Development Plan-SDP) and addresses government strategies (Drivers of Crime, Suicide Action Plan, welfare reforms).

Progress to date

Adult and Primary Care:

Access rates for Māori adults reached 11.5% and 3.9% for all adults against targets of 8.18% and 3.3% respectively. 88.6% of adults' accessed non-urgent mental health services within 3 weeks and 96% accessed within 8 weeks against targets of 80% and 95% respectively. Six core strategies are in place to reduce use of restraint and seclusion. On-going hospital service clinical staff training is in place to reduce adult suicide rates. A collaboration project is underway with Waitemata DHB looking at employment services (across sectors).

Child and Youth:

The Child and Youth Mental Health and Addictions Direction (2013 to 2023) was completed and signed off by the Board. The Kari Centre established school liaison roles and following a process improvement methodology they identified a new service model which will incorporate an acute response, assessment and brief intervention team managing triage using an approach informed by Choice and Partnership Approach (CAPA). Access rates for Māori youth reached 5.08% and 3% for all youth against a target of 3%. 69.5% of 0 to 19 years accessed non-urgent mental health services within 3 weeks and 95.5% accessed within 8 weeks, against targets of 80% and 95% respectively.

Older People:

Access rates for Māori older adults reached 3.9% and 3.6% for all older adults against an overall target of 3.58%. 69.9% of older adults accessed non-urgent mental health services within 3 weeks and 94% accessed within 8 weeks against targets of 80% and 95% respectively.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Review of duration of service use to ensure that people are engaged at the right level of service at the right time (using resources effectively/links to Stepped Care) by June 2015 • Maximise the percentage of staff time spent in direct service delivery through specific projects in Child and Adolescent Mental Health Services (CAMHS)/Adult and Mental Health Services for Older Persons (MHSOP) led by the Productivity Working Group – on-going • 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 – set of recognised trainings run six monthly	• Continue to meet mental health and addictions service waiting times: 80% within 3 weeks and 95% within 8 weeks (PP8) with a special focus on 0-19 age group • Measure percentage of productive individual client related face-to-face staff time in adult services with the aim of meeting the national target (25% by December 2014 and 30% by June 2015) • Suicide prevention and postvention plan fully implemented by June 2015 • At least 95% of child and youth clients discharged will have a transition (discharge) plan (PP7) • At least 95% of Māori and Pacific long term clients will have up-to-date relapse prevention

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Continue to strengthen the cross agency collaboration in regard to suicide prevention and postvention through on-going networking with core agencies (eg Victim Support and Child Youth and Family Services (CYFS) - ongoing • Improve collection and utilisation of HONOS data and complete roll out of Hua Oranga across both Waitemata and Auckland DHBs by June 2015 • Build system and clinical integration with primary, hospital and non-governmental agency (NGO) services by developing the role of NGO support workers and peer specialists in supporting the transitions across primary and hospitals, with a focus on the development of integrated treatment pathways • Monitor consult-liaison sessions delivered by s care to primary care, schools and other public sector agencies – on-going • Develop a collaborative plan with primary health organisations (PHOs) to support mental health workforce capability in primary care (Waitemata DHB and Auckland DHB) on-going • DHB specialist clinicians will support the primary care sector to increase workforce mental health capability – on-going • Participate in Auckland DHB Whānau Ora initiatives (e.g. Orakei) including co-location into community/Whānau Ora services and inclusion of Kaupapa Māori mental health NGOs over 2014/15 • Set bench marks for access and readmission rates for Māori, Pacific and Asian with an aim to reduce late access to service, i.e. first presentation to service resulting in acute admission to an in-patient unit, with a focus on early access for youth by June 2015 • Continue to implement the long term restraint/seclusion minimisation strategy with a goal of zero use by 2020 • Integrate AOD interventions across the continuum with a focus on the Integrated Pathways between the Auckland District Court "Court of New Beginnings" (homeless court) and Community Alcohol and Drug Services (CADS) and NGOs; and the Auckland Drug Court (links to Drivers of Crime) by December 2014 • Implement the 2014/15 actions from the Auckland DHB Child and Youth Mental Health	plans • Project for the Integration of Mental Health Data (PRIMHD) file success rate and data quality (OS10) • A minimum of eight actions from across the four goal areas in Rising to the Challenge identified in the Annual Plan are delivered as a policy priority deliverable in 2014/15 (PP26) • Integrated treatment pathways are documented • Consult liaison session data is collected: targets set in June 2014 are met in the 2014/15 year • 200 structured AOD assessments delivered for each of the Auckland and Waitakere Drug Courts and 20 for the Court of New Beginnings • New local Infant and Perinatal Mental Health Services are fully implemented by Q3 – service development funding: $1,225,452.96.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
and Addictions Direction (2013 to 2023) with interagency partners, focusing on early intervention and prevention by June 2015 • Complete the implementation of the new service model for Kari Centre incorporating an acute response, assessment and brief intervention team managing triage using a CAPA style approach by December 2014. This team will also include the development of the interface and liaison with Procare as the lead primary mental health provider for young people in the Youth Service Level Alliance • Implement mental health initiatives including respite beds and support packages for women with maternal mental health issues over 2014/15 • Participate in the implementation of the first stage of the Dementia Care Services pathway over 2014/15 • Develop a project to map and improve service access and pathways across the various Ministry of Social Development and health employment contracts (link with Waitemata DHB project) by December 2014 • The mental health ring fence will be maintained (the calculation will include demographic and cost pressure increases). Any additional funding allocation will be prioritised to gaps in the Service Development Plan and Prime Minister's Youth Mental Health stock-takes – on-going • Participation in regional work (eating disorders, infant and Peri-Natal Mental Health (additional new operational funding $1.225m), High and Complex needs, Māori workforce development and Youth Forensics), is included in the regional plan – on-going • Adult Forensic Psychiatry - track that the percentage of mentally unwell prisoner admissions to Forensic Inpatient Services that meet the agreed Prison Model of Care acute and sub-acute targets is maintained or increased over 2014/15 • Continue to build capacity in the Youth Forensic teams as additional funding allocation is agreed regionally for 2014/15.	

Maternal and Child Health

What are we trying to do?

We want to improve access, quality and outcomes and reduce inequalities for women, babies and infants in Auckland DHB through the delivery of effective, integrated, evidence-based maternity and children's services.

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 are more likely to become healthy adults. Positive health outcomes for children and mothers are essential for 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. An effective interface between maternity carers and other primary healthcare professionals needs to support these aims.

Progress to date

Our infant mortality rate of 4.6 per 1000 live births (2006-2010) is similar to other districts. Between 2008 and 2010 we had 0.8 deaths per 1000 live births as the result of sudden unexplained death of an infant (SUDI), similar to other DHBs. The most recent data suggests that deaths from SUDI are beginning to decline. While many families living in Auckland have better health than their national counterparts, some remain significantly disadvantaged with Māori and Pacific children having poorer health status than other groups.

Our on-going collaboration on specific projects under the Northern Regional Child Health Plan includes SUDI, rheumatic fever, skin sepsis, respiratory illness and unintentional injury. Maternity Quality and Safety Programme Plans continue to be implemented with a strong focus on the Ministry of Health developed clinical indicators, embedding clinical governance and progressing specific quality improvement activities (regional collaboration on Induction of Labour guidelines). Work has commenced on understanding barriers and enablers to early LMC engagement. 64% of women were enrolled with a LMC at 12 weeks of pregnancy (2012). 59% of children with high needs and 75% of total children received B4 school checks.

A Virtual Clinic Service for women experiencing a post-dates pregnancy and an antenatal iron infusion policy to address rates of transfusion after vaginal birth have been implemented. As well as this, we have implemented the Positive Birth after Caesarean Section service, which has increased the number of women experiencing a trial of labour.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Complete the Auckland and Waitemata DHB maternity review and develop an agreed combined plan. Initiate an implementation plan for the preferred option. ***Actions to improve Access will include:*** • Informed by Ministry of Health data and survey/interview results develop targeted strategies to facilitate early registration with a LMC (by 12 weeks pregnant); strategies may include awareness raising and working with GPs	An agreed plan across Auckland and Waitemata DHBs for the configuration of maternity services is presented to the Boards by March 2015. ***Access*** • At least 80% of pregnant women are registered with a LMC by week 12 of their pregnancy • 88% of new born children are enrolled with a GP by three months by December 2014 and 98% by June 2016 • 86% of Māori and Pacific infants will receive all

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
and LMCs by January 2015 • Work closely with the immunisation team leading the new born early enrolment with a GP/PHO workstream to build on elements of previous work, identify current gaps and examine maternity specific actions by June 2015 • Work with Well Child Tamaki Ora (WCTO) providers and other community providers to plan and implement targeted strategies to improve early WCTO enrolment, and support Māori, Pacific and young mothers to attend all core WCTO checks in the first year of life by June 2015 • Continue to develop systems to enrol children early with the community oral health provider (Auckland Regional Dental Service) through preschool co-ordinator activities – on going • Provision of patient-centred appointments, confirming attendance either by texting or telephoning and by extending clinic hours to suit parents/caregivers to reduce preschool dental non-attendance (DNAs) by March 2015 • Monitoring engagement of Māori infants with community oral health providers, and working on whānau engagement with community oral health services – on-going • Implementation of the revised Ministry of Health Pregnancy and Parenting service specifications through a request for proposals process to provide more effectively targeted pregnancy and parenting education and information services. The design of this service will specifically involve Māori and Pacific groups by 31 January 2015 • Following implementation of the service specification, establish baseline data on the engagement in pregnancy and parenting education services by ethnicity by 31 July 2015 • Communicating up to date key messages and information about well child provider options through the redevelopment of a brief information brochure for pregnant women, and to promote consistency of messaging with health providers by March 2015. ***Actions to improve Quality will include:*** • Refining the reporting and utilisation of the Maternity Clinical Indicators alongside other	WCTO core contacts through their first year • 95% of preschool children are enrolled with the Auckland Regional Dental Service • 93% of enrolled children are seen for their oral health assessments on time • 90% of four year olds receive a B4 School Check, including 90% of children living in high deprivation areas • Baseline data collected for pregnant women who are engaged in quality antenatal education, by ethnicity. ***Quality*** • There will be assessment of progress using the New Zealand Maternity Clinical Indicators and the development of specific activities around indicators of concern • Improved quality and safety of maternity services as directed by the Maternity Quality and Safety Programme. Improvements will be shown by patient experience survey results and a range of indicators in the Annual Clinical Report • The national guideline for the screening, diagnosis and management of gestational diabetes will be implemented • Of the children who complete a B4 School Check, at least 85% have their Check started before they are 4 ½ years of age. ***Outcomes*** • At least 55% of all children, especially Māori, Pacific and Asian are fully breastfed at three months of age.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

key indicators and use these to develop targeted quality improvement activities – on-going
• Progressing specific projects under the Maternity Quality and Safety Plans, including:
  ○ Promoting the Normal Birth Project
  ○ Increasing early engagement with a LMC by June 2015
• Implementing the national guideline for the screening, diagnosis and management of gestational diabetes once available
• Improving B4 School Check timeliness by increasing the number of children offered a B4 School Check before they turn 4 ½ years of age by working with GPs, practice nurses, early childhood education providers, Well Child providers, Healthy Village Action Zones and other welfare providers to refer four year old children for their B4 School Check by March 2015.
Actions to improve Outcomes will include:
• Maintaining breast feeding friendly hospital initiative accreditation and investigating opportunities to extend the concept into primary care settings by 28 February 2015
• Increasing messaging and community support to Māori, Pacific and Asian women and their families and whānau to encourage continuation of breast feeding from six weeks to three months, linking with the Maternal and Infant Nutrition Project by March 2015
• Work with Well Child Providers and LMCs to develop activities identified by the WCTO Quality Framework breastfeeding workstream from August 2014 on-going
• Support the Health Promotion Agency work programme toward the prevention of children being born with Foetal Alcohol Spectrum Disorder (FASD) on-going.	

Priority Populations

Māori Health

What are we trying to do?

We want to ensure that Māori achieve their best possible health outcomes. 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 want to identify and effectively manage chronic conditions such as cardiovascular disease and diabetes. We also seek to ensure Māori wellbeing is maximised by working with Māori partners, including iwi and local Māori providers, in a framework that 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 a gap of 7 years in life expectancy between Māori and non- Māori. Coronary heart disease, lung cancer, diabetes, obesity and stroke account for over half of this difference. Therefore there is substantial scope to improve health gain for Māori. By focusing on risk factors as well as better management of existing conditions, we can improve health outcomes. 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 life expectancy in Auckland DHB is 75 years, 1 year above the national average for Māori across New Zealand (74 years) at birth (between 2008-2012). As well as achieving the advice to quit smoking health target in hospital services there has been significant improvement in immunisation uptake and breast screening (70.2% as at January 2014). Cervical screening rates have improved from 49% to 57.1% over the last three years. We lead the country in the achievement of the More Heart and Diabetes health target for Māori. Heart and diabetes checks increased from 79.1% to 80.4% (as at December 2013). The increased numbers of recruited Māori nurses across service areas will, over time, contribute to health gain.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
Access to primary care • Work closely with PHOs to ensure that Māori Health Plan targets are met by all PHOs by June 2015 • Collaborate with PHOs to implement all three stages of the Ministry of Health Ethnicity Data Audit Toolkit in general practices by June 2015 • Work with PHOs to ensure that the quality of ethnicity data at PHO level is high (i.e. address issues with Datalink) by June 2015 • Collect and analyse information about the conditions driving ambulatory sensitive hospitalisation (ASH) rates in the 45-64 year age group by June 2015	Achievement of the following national Māori health targets • PHO enrolment (Māori): 95% • 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: Auckland DHB 1.9 per 100,000 population (n=9).

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Promote and transfer the learnings from targeted community based partnership responses which are shown to be effective in reaching Māori and increasing access (sentinel practices for rheumatic fever swabbing and 65 years+ Kaumatua community based seasonal influenza vaccination clinics are examples) by June 2015 • Support development and implementation of Whānau Ora models of care and delivery, via the development of further business cases and future programme modelling by June 2015. ***Chronic conditions*** • Continue to analyse care pathways to identify, isolate and address inequalities gaps with appropriate service groups by June 2015 • Identify opportunities to increase access in community settings by June 2015. ***Smoking cessation*** • 95% of Māori seeking post discharge support to quit smoking, will be followed up to ensure they have had every opportunity to engage with a Smoking Cessation Service best suited to their needs by June 2015 • Identify best practice approaches to encourage 15-24 year olds to be smokefree by June 2015 • The Maternity Plan will be updated with new activities to encourage pregnant Māori women to quit smoking by June 2015 • Identify Māori leaders/champions in the community (e.g. Aunties) to work with whānau to promote smoke free by June 2015 • Provide training to all Māori Health Service/He Kamaka Waiora registered staff to be smoking cessation leads with on-going support through the Auckland DHB Smokefree Team by June 2015. ***Health of older people*** • Identify and progress options to support Kaumatua in residential care by June 2015 • Identify eligible patients who have not had 'flu' vaccination and offer vaccination by June 2015 • Review of older adult service completed and recommendations implemented by June 2015. ***Child health*** • Development of a strategy to increase enrolment (GP, Well Child and oral health), immunisation	

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
and B4 School Checks in collaboration with primary care, Māori providers and NGOs by June 2015 • Support the implementation of the Auckland DHB acute rheumatic fever programmes by June 2015. ***Māori workforce development*** • Develop a clinical leadership governance structure for Māori by June 2015 • Develop five specific Māori clinical positions by June 2015 • Support the Kia Ora Hauora initiative to support young Māori into careers in health through the Rangatahi Programme by June 2015. ***Womens health*** • Review the quality of ethnicity data within the breast screening programme by June 2015 • Support the implementation of the work programme of metro Auckland Cervical Screening Steering Group by June 2015.	

Pacific Health

What are we trying to do?

We want to improve Pacific health outcomes by reducing the prevalence of modifiable risk factors such as smoking and improving the identification and management of long term conditions. We need more people engaged in this effort. We want Pacific people to have good health literacy, communities and churches to be 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 9 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 their health care experiences are always positive.

Progress to date

The national health target for immunisation of 90% at 8 months was exceeded by Auckland DHB at 93% and the better help for hospitalised smokers to quit target of 95% was also reached with a reduction in smoking prevalence. Breast screening targets were met at 89.6% and the more heart and diabetes target of 90% was almost met at 85.4% - the highest in the country. 56% of people with diabetes who had an annual review had satisfactory diabetes management. A joint Auckland/Waitemata DHB Pacific Strategic/Action Plan has been developed with extensive community wide consultation to build on and extend improvements.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Implement the Pacific Action Plan priority areas. This includes:
  ○ Family violence prevention – trial programme on at least two church communities by June 2015
  ○ Smokefree – train smoke free champions for Healthy Village Action Zones (HVAZ) churches by June 2015
  ○ Diet and exercise – continue regular physical activity groups and nutrition education sessions with HVAZ – on-going
• Self-management education (SME) lay facilitators will be trained to facilitate SME workshops in the Auckland DHB by 30 June 2014
• SME and DSME will be delivered to Pacific communities in Auckland DHB – on-going
• Pacific providers and community leaders will participate in the Tamaki locality work over 2014/15
• AH+ participation in Auckland DHB local health partnerships will continue-on-going
• HVAZ programmes will continue – annual weight loss competitions and group quit smoke competitions will be held; nutrition training will be on-going
• Collaborate with the Pacific Hospital Support Team and other hospital services to further explore barriers and solutions to non-attendance at hospital outpatient appointments (DNAs) and thereby reduce DNAs by June 2015.
	• 90% of Pacific children are up-to-date with their immunisation at 8 months by June 2015
	• 95% of Pacific children are up-to-date with their immunisation at 24 months by June 2015
	• Five year heart and diabetes check completed by general practice/ nurse led clinics for 90% of the eligible Pacific population by 30 June 2015
	• 75% of eligible Pacific population will achieve good diabetes management by June 2015
	• 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 by June 2015
	• Continue to meet or exceed 70% target of Pacific participation in breast screening programme over 2014/15
	• Increase Pacific participation in cervical screening to 80% by June 2015
	• 33% HVAZ church halls and grounds will become smoke free by June 2015.

Asians, Migrants and Refugees

What are we trying to do?

Auckland DHB wants to improve the overall health status of Asians, new migrant and refugee populations living in the Auckland district. We will continue to focus on identified areas of high need and staff cultural competency and address barriers such as access to health services and language.

Why is this important for community and patients?

The Asian population now accounts for 31% of Auckland's population and is increasing. It is expected that all New Zealanders, regardless of ethnicity, receive an equitable level of health service access, care and outcomes. The Asian and MELAA populations living in the Auckland region are high and rapidly increasing. These groups have specific health needs. There remain some inequalities in access particularly in relation to PHO enrolment, cervical screening, mental health, and chronic disease (including diabetes and cardiovascular disease).

Progress to date

Asian life expectancy at birth is the highest in Auckland at 84 years (2009-2011). We have continued to implement the Auckland DHB Asian Health Action Plan. Key achievements include:

- Asian PHO enrolment rate: Auckland DHB 74%
- 61% three year coverage rate for Asian women cervical cancer screening
- Childhood immunisation rates at 8 months exceeding national target of 90%
- Childhood immunisation rates at 2 years exceeding national target of 95%.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Regular six monthly communication with MoH and other Health and Disability organisations to follow the Ethnicity Data Protocols to report on level 1 'Asian' and 2 categories subgroups ('Other Asian', 'Chinese', 'Indian', 'South East Asian' and 'Asian NFD') by 30 June, 2015 • Establish complete and accurate data on level 2 Asian subgroups to guide planning and monitoring of services by 30 June, 2015 • Expectations for achievement of 90% 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 by 30 June, 2015 • Northern Regional Diabetes Network indicators utilised as measurement tools by 30 June, 2015 • Continue to provide free smears for Asian women not screened in the last 5 years or never screened (on-going) • Maungakiekie- Tamaki locality – Mental Health model of care with Asian, MELAA, new migrant and refugee inputs scoped and developed 1 April, 2015 • Workforce development training to health professionals on refugee health across Auckland DHB by June 2015 • Set benchmarks for mental health access rates for Asian, and aim to reduce late access to service i.e. first presentation to service resulting in acute admission to an in-patient unit, with a focus on early access for youth by 31 December 2014.	• 90% of eligible Asian people will have had a heart and diabetes check within the last five years by 30 June 2015 based on accurate ethnicity data collection and reporting protocols • 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 by 30 June, 2015 • 65% of Indian people who have had a diabetes annual review will have an HbA1c of <64mmol/mol by 30 June, 2015 • 65% of eligible Asian people will receive the Diabetes Care Improvement Package over the year to 30 June, 2015 • Increase breast screening rate to 70% by 30 June 2015 • Work towards increasing cervical screening coverage rate to at least 80% by 2020 • Achieve 95% of the Asian immunisation rate of 8 month and 2 year olds by 30 June 2015 • Maungakiekie-Tamaki locality - Integrated model of care for Mental Health includes culturally appropriate strategies for Asian, Middle Eastern, Latin American or African ethnicity (MELAA),new migrant and refugees by 1 April 2015 • At least 55% of Asian infants are fully breastfed at three months of age • Three refugee forums delivered annually across Auckland DHB and Waitemata DHBs by 30 June 2015 • Establish baseline data for mental health access rates for Asian and set targets for 2015/16.

Patient Experience and Quality

Patient Experience

What are we trying to do?

Consistent with our vision of patient and whānau determined health; we will work together with patients, whānau and communities to help them achieve the health outcomes they want. For 2014/15 we will have a particular focus on how we communicate with people.

Why is this important for community and patients?

There is increasing evidence that health outcomes are affected not only by the quality of technical care received, but also by the quality of interpersonal relationships (ie. between staff, patients and families). Good patient experience and good clinical quality go hand-in-hand.

Progress to date

We have provided specific open disclosure training workshops in partnership with the Medical Protection Society for senior clinicians and developed and delivered experience-based co-design professional development/education to 15 staff. We have completed an initial 'Patient and Family Centred Care' current state assessment and undertaken case-studies in 'Patients and Families as Partners in Care'. We have also reviewed our complaints process as well as all Severity Assessment Code (SAC) 1 and 2 adverse events and recommendations communicated to stakeholders.

We have developed patient and clinician tools and resources to increase awareness and encourage conversations about Advance Care Planning. Advance Care Planning training is well established and over 100 Auckland DHB staff members have attended the Level 2 practitioner training. Accelerated Releasing Time to Care Programme commenced in 15 wards with 120 staff directly involved. We have also successfully completed a 24/7 support person trial as part of Families as Partners in Care project in 7 wards.

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.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Undertake a health literacy review of the DHB that will include reviewing how we communicate with our patients, whānau and communities with a view to developing new channels to connect with people and improve way-finding across Grafton and Greenlane sites by June 2015, including an upgrade of signage • Training in patient-based communication values, skills and techniques developed by June 2015 • Patient and Family-Centred Programme developed by December 2014 • Build on the patient experience survey to make it more representative of our patient population (including mental health patients) and be more	• Percentage of patient experience survey respondents rating 'communication', quality of care', and 'care coordination' as 'very good' or 'excellent' increases from 82% to 85% by June 2015 • Percentage of patient experience survey respondents rating their overall experience as 'very good' or 'excellent' increases from 82% to 90% by June 2015 • 100% of all patients/families impacted by SAC 1 or 2 adverse events will have open disclosure of the facts, including review findings by October 2014.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
responsive to emerging themes by June 2015 • Increase percentage of patients who receive a copy of their clinic letter when attending ambulatory services from 20% to 70% by June 2015 • Rollout of the nominated support person 24/7 as part of the Auckland DHB Families as Partners in Care implementation plan by June 2015 • Continue the development of a 'Patient, Family and Community Engagement Framework' to integrate and guide hospital and community based engagement activity – on-going • Engage patients, families and the community to improve services including co-design programmes and involving patients and community representatives in project teams – on-going • Consolidate the patient and family centred approach to care delivery- on-going • Commit to re-design of Auckland City Hospital 'front door' experience by December 2014 • Collaborate with sub-regional and regional DHB colleagues and the Health Quality and Safety Commission's (HQSC's) 'Partners in Care' programme – on-going • Work with NGOs, primary care, the private sector, Auckland University of Technology (AUT) and the HQSC to develop organisational capability to improve consumer experience – on-going • Work with healthAlliance to establish the information technology infrastructure (e-shared care) for the capturing and sharing of Advance Care plans across the care continuum by June 2015 • Review and amend policy about open-disclosure for all major adverse events to clarify expectations and process for disclosure to patients and families by December 2014.	

Quality

What are we trying to do?

Create a health system which delivers high quality health care, reduces avoidable patient harm, improves clinical effectiveness and provides a positive patient and family experience.

Why is this important for community and patients?

We need to continuously earn the trust placed in us by our community. Patients and families need to be confident of the quality and safety of the care they will receive and know that that care is best practice.

There is increasing evidence that the more involvement a patient and their family / whānau have in their care, the better the outcomes. Designing patient centred systems through clinically led improvement will enable patients to receive the type of health service they need.

Progress to date

Auckland DHB's implementation of the Health Quality and Safety Commission's "Open For Better Care Campaign" has resulted in hand hygiene compliance increasing to 75% in 2013, up from 70% in 2012 and central line associated bacteraemia (CLAB) decreasing by 40%. Regional collaboration on the 'First Do No Harm' (FDNH) projects has reduced both pressure injuries and falls resulting in serious harm by 20%. Auckland DHB's first Quality Account has been published.

A co-design methodology has been integrated into our Performance Improvement Programmes. This enables Auckland DHB to work in partnership with patients and families to improve service quality and safety, including patient experience. An End of Life Strategy has been developed. This includes Advance Care Planning (ACP), bereavement resource information for families, and education for staff and families.

A further 20 staff have been trained as Improvement Practitioners in 2013 (now 100 in total) and over 120 staff have been trained in Improvement Fundamentals (now over 300 in total). Examples of improvement projects include the reduced use of haemophilia recombinant products with timely bleed reporting, and better patient pathways which give certainty to the patient about treatment and reduce the number of bed days required by the hospital. These initiatives and many others are acknowledged each year as part of Auckland DHB's annual Healthcare Excellence Awards.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

• Collaborate with regional DHBs, colleagues and the Health Quality and Safety Commission's (HQSC) patient safety programme and consumer experience programme – on-going
• Implement the following to meet the hand hygiene QSM on-going:
  ○ Train one frontline staff member in each area to gold auditor level
  ○ Provide alcohol based rub at all points of clinical care, at the entry to each clinical area and to public and staff eateries.
  ○ Introduce purpose driven glove wearing at Auckland
  ○ Distribute new patient leaflets with information on "what to expect to see" for hand hygiene and posters about keeping safe with clean hands
• Roll out surgical checklist compliance project – including establishing a lead person, clinical education, promotion and audit – across all operating theatres, commenced by September 2014
• Continue antibiotic prophylaxis programme for elective joint replacement surgery, including monthly audit – on-going
• Provide all patients in pre-admit clinic with both
	• Maintain hand hygiene 5 moments compliance at 76% and working towards 80% or higher compliance with good hand hygiene practice
	• Maintain the rate of healthcare-associated staphylococcus aureus blood stream infections at < 0.2/1000 inpatient days
	• 90% compliance with central venous line maintenance bundles
	• 90% of operations will use all three parts of the surgical checklist
	• 95% of non-allergic hip and knee replacement patients receive cephazolin ≥2g as surgical prophylaxis by December 2014
	• 100% of hip and knee replacement patients have appropriate skin preparation
	• 90% of patients aged 75 and over (Māori and Pacific 55 years and over) are risk assessed for falls
	• Participated in the regional FDNH and HQSC medication safety campaigns
	• Enhance the system for the reporting of pressure injuries
	• Produce a 2013-14 Quality Account as advised by HQSC
	• A risk register for enterprise risk is provided for senior management and Board. Individual risk

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by

verbal and written education on how to prepare for their surgery. Any clipping required is confirmed by the surgeon and performed in theatre. Audit results data provided to national committee when received
• Actively participate in the regional 'First do no Harm' and clinical network projects:
  ○ Research and design a project for prevention and improved management of community acquired fractures and implement a fracture liaison service by June 2015
• Support the medication safety campaign – on-going
• Ensure that there is a process to rate and report all grade 3 and 4 hospital acquired pressure injuries to Severity Assessment Code (SAC) 2 – on-going
• Annual publication of the Quality Account
• Develop Auckland and Waitemata DHB-wide risk management programme
• Develop Auckland DHB enterprise-wide, Directorate and Support Service level risk registers by June 2015
• Increase advance care planning activities as more staff are trained – on-going
• Implement an in-hospital venous thromboembolism (VTE) risk assessment programme by June 2015
• Introduce electronic medicines reconciliation for priority patients
• Review medicine imprest process to identify wastage and efficiency opportunities
• Review of efficacy of falls prevention interventions to maintain performance – on-going
• Establish surveillance of three types of surgical site infection:
  ○ Central lines – on-going
  ○ Adult and paediatric cardiothoracic Surgery by 1 July
  ○ Hip and Knee Arthroplasty – on-going
• Increase capability and capacity of staff through:
  ○ Formal quality improvement skills training programmes (Improvement Practitioner and Improvement Fundamentals) – on-going.
• Develop a programme of reporting clinical governance and assurance activity to Auckland DHB Board.
	registers are provided to each directorate. Appropriate training and education has been implemented into all directorates
	• 30 additional staff trained in ACP
	• Numbers of staff trained in ACP, increase in staff awareness of ACP from 40% to 50%
	• 20% increase on 2013/14 result in the numbers of 'conversations that count' documented in the patient record
	• 90% of adult patients have documented VTE risk assessment
	• Electronic medicines reconciliation early adopter pilot completed by June 2015
	• Medicine imprest process review completed by June 2015
	• Falls and pressure injuries steering group meeting held bi-monthly
	• 25% reduction in surgical site infections across prioritised procedures
	• Improvement skills training completed for 200 staff
	• Key findings and recommendations from serious adverse event investigations are published in the public section of board reports
	• The development and presentation of a method to capture audit activity which aligns mandatory professional requirements with integrated governance priorities.

Living within our Means

What are we trying to do?

Be a financially sustainable and productive organisation while improving health outcomes and reducing inequalities for our community.

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 hospital and tertiary services for other regions' populations is also a significant factor. For some services, the growth is substantially higher than the growth of our population particularly in cancer and heart disease which remain the biggest health problem area for our DHB.

As the major New Zealand provider of tertiary services, about 50% of the income of our provider comes from other DHBs.

Progress to date

In 2013/14 we have continued to focus on the business transformation programme to deliver savings from improved efficiencies, innovation and changes in systems and processes. We have continued to live within our means each year, achieving financial results better or equal to our annual plan. A similar financial result is expected for 2013/14 with a forecast financial position of an operating surplus of $0.3m. This is due in part to the realisation of transformation savings across the organisation.

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
For 2014/15 one of our key priorities is to continue with a business transformation framework for long-term financial and service sustainability in line with our strategic plan. With the recently established single point of accountability we will have an enhanced clinical leadership model to improve patient experience, enhance quality outcomes and deliver healthcare services more efficiently. The business transformation programme will continue into 2014/15 and beyond. The key areas of focus of this programme, to be delivered by June 2015, will include the following: • Implementation of service delivery models including system-wide design and appropriate purchasing of services for Older People, Mental Health and Children's Services • Reviewing and implementing medical personnel skill mix changes across the organisation to achieve improved efficiency and productivity – on-going • Reconfiguring the surgical services model,	• Increase in other revenue streams through commercial contracts, research funded studies, bequest programme, collaboration in research service with other DHBs, systems improvement – increases realised by June 2015 • Continue to work with the National Health Board in the 2014/15 year to ensure a sustainable model for tertiary services • Development of region-wide service delivery models by June 2015 • Delivery of targets described in regional work-streams in 2014/15 by June 2015 • Training posts and associated costs identified and mitigated by June 2015 • Maintaining the capped FTE levels agreed in the Annual Plan for non-clinical staff – ongoing • Detailed savings included in the Auckland DHB financial budgets (with monthly phasing) will be reported to the NHB on a monthly basis

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
including production planning and improved utilisation of theatres • Implementing Support Service agency savings from procurement, inventory control and back-office efficiency initiatives (HBL, HealthAlliance) • Pharmac and healthAlliance are working jointly on the national procurement of medical devices for best health outcomes – on-going • Implementing revenue generation strategies through commercially funded research studies, service contracts, bequest programme, sharing research service, research cash-flow timing, systems control among other clinical and non-clinical revenue generation strategies • Funder service review • Working with other DHBs to define the tertiary services they wish to have provided for their populations and the cost they wish to pay. Match service delivery to income Work within the Northern region to determine the most clinically appropriate and cost effective pattern of service provision to meet patient need and access • Working with the National Health Board and Ministry to determine the specifications of national services matched to financial allocations on-going • Supporting the work of HBL to develop a business case aimed at reducing the costs of food, linen and laundry services while improving the overall quality and provision of these services • Support the HBL development of the detailed National Infrastructure Platform business case and provide input as required and as appropriate. Commitment of resources is subject to Board decision on the completed business case • Reviewing the capacity to maintain the level of training posts within the DHB • Implementing clinical support service efficiencies in Laboratory, Radiology etc.	

MODULE 3: Statement of Performance Expectations

The statement of forecast service performance is a requirement of the New Crown Entities Act 2013. It identifies outputs, measures, and performance targets for the 2014/15 year.

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

Cost of Outputs

Auckland DHB 2014/15 Output Class Reporting / Statement of Service Performance

Old Output Class Name	Public	Primary	Hospital	Support	Total
New Output Class Name	Prevention Services ($'000)	Early Detection and Management ($'000)	Intensive Assessment & Treatment ($'000)	Rehabilitation and Support ($'000)	Total ($'000)
Total Revenue	19,689	561,595	1,306,460	169,139	2,056,883
Expenditure					
Personnel	15,627	18,962	783,714	14,121	832,425
Outsourced Services	1,020	1,513	86,881	238	89,652
Clinical Supplies	423	12,269	216,910	3,451	233,053
Infrastructure & Non-Clinical Supplies	2,248	3,740	167,451	2,320	175,760
Payments to Providers	1,100	520,139	56,529	148,198	725,967
Total Expenditure	20,419	556,623	1,311,486	168,329	2,056,857
Net Surplus / (Deficit)	(730)	4,972	(5,026)	810	27

Targets and Achievement

Auckland DHB's focus for 2014/15 is on making a positive impact on health outcomes; making sure people have a positive experience of our health services; and using resources efficiently. Our actions in 2014/15 need to contribute directly to the outcomes we want over the longer term. The outcomes and impacts in this section link to the national, regional and local strategic direction covered in Module 1 of this document.

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

The criteria used to allocate these grades are as follows:

Key to Output Tables

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	

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

Output Class 1: Prevention Services

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

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

Approximately a third of the burden of ill health is preventable and for some diseases such as cardiovascular disease the percentage is much higher. Effective prevention services can therefore have a significant impact on health outcomes. From a financial sustainability or efficiency perspective, an expedient 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 Promotion

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.	Q	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	97.7%	95%	Q2 2013/14
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit	Q		55.2%	90%	Q2 2013/14
Number of people accessing Green Prescriptions	V	A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. GRx research confirms this is a cost-effective way to help people stay healthy.	4953	6,062	90% of 2013/14 target est
Enforcement of the Smokefree Environments Act 1990					
Number of retailer compliance checks conducted	V	Compliance checks are conducted with tobacco retailers to ensure they are meeting their obligations under the Smokefree Environments Act 1990.	457	300	2012/13
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted	V	Preventing minors from accessing tobacco products contributes towards the prevention of smoking initiation. These are output and impact measures.	498	300	2012/13
Enforcement of alcohol legislation					
Number of license applications (on5, off club and special) risk assessed	V	ARPHS works to reduce the proportion of premises which sell alcohol that are of high or extreme risk. All license applications in Auckland region are risk assessed	1235	1200 est	2012/13
Number of premises visited where joint Controlled Purchase Operations (CPOs) were conducted (alcohol)	V	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 output and impact measures.	325	400	2012/13

[5] 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)

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Legislation advocacy and advice					
Numbers of submissions made (demand driven)	V	Submissions make up a high proportion of the policy work. The number reflects the volume of output although some involve more work than others	26	25 est.	2012/13

Output: Health Protection

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Communicable disease surveillance and control activities					
Total number of communicable disease notifications per reporting period	V	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.	5,597	5,500 est.	2012/13
Number of notifications investigated and found to be a confirmed or probable case	V		4,706	4,500 est.	2012/13
Tuberculosis (TB)					
Number of TB contacts followed up	V	Investigating and following up TB contacts minimises morbidity and transmission of TB.	795	750 est.	2012/13
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	ARPHS ensures that an appropriate medication regimen is prescribed to TB and LTBI patients that require medication.	81%	≥85%	2012/13
Percentage (and number) of eligible infants vaccinated with a BCG	C	Preventable TB continues to occur among New Zealand children in high risk groups. Vaccination is delivered by ARPHS through hospital and community-based programmes.	98.4% (total 4,811)	≥99% total (4,800 est.)	2012/13
Refugee health screening service					
Number of quota refugees screened	C	The medical screening aims to protect the New Zealand population via prevention of the spread of communicable diseases and to protect and promote the health of refugees	848 (750 + 13%)	750[6]	2012/13
Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule	C	Assessing immunisation status forms part of the refugee screening process. This supports the increase of	98%	98%	2012/13

[6] The New Zealand Government, in agreement with the United Nations High Commissioner for Refugees, has a refugee quota programme which offers 750+ / - 10% places per year.

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
		infant and adult immunisation rates.			
Drinking water quality					
Percentage of the population that received drinking-water from fully compliant supplies	Q	High compliance with the standards will indicate that ARPHS is helping reduce population exposure to water-borne pathogens. This is a measure of impact.	97%	≥95%	2011/12

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

Output: Population Based Screening

Population Based Screening	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Breast Screening					
Coverage rates among eligible groups	C	Coverage is a standard measure of output from screening programmes.	70%	70%	2 years to September 2013
Newborn Hearing Screening					
Number/proportion of babies screened	V	Coverage is a standard measure of output from screening programmes	8493 or (100%)	76%	December 2012 - November 2013
Referral rate to audiology <=4%	Q	Reflects the quality of the service	1.75%	<=4%.	December 2012 – November 2013
Appropriate medical and audiological services initiated by 6 months of age for infants referred through the programme.	T	A timely service provides prompt access	100%	>=95%	December 2012 – November 2013

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

Output Class 2: Early Detection and Management

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

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

Our patients' experience is improved and suffering reduced, through timely access to services, reassurance in the case of negative results and prompt management of complaints and incidents. Effective early detection and management of patients reduces demand on more costly hospital and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

Output: Primary Health Care

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Primary care enrolment rates	C	Primary care enrolment rates give an indication of access to primary care health services.	92%	95%	Q2 2013/14
Immunisation health target achievement - 95% of eight month olds fully immunised by December 2014☑	C	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 and the impact of our services in achieving heart immunity	94%	95%	Q2 2013/14
Cervical screening coverage	C	As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care	77.1%	80%	3 year coverage as at September 2013
Percentage of B4 School Checks completed	C	Coverage is a standard measure of output from screening programmes	37%	90% (year end)	As at Q2 2013/14
Percentage of diabetes patients with satisfactory or better diabetes management (HbA1c ≤64mmol/mol)	Q	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	71%	75%	Q2 2013/14
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C		83.2%	90%	Q2 2013/14
GMS claims from after-hours providers per 10,000 of population	T	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	296 per 10,000	Ω	2012/13
Proportion of practices with cornerstone accreditation	Q	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	50%	↑	As at December 2013

Output: Community Referred Testing & Diagnostics

Community Referred Testing and Diagnostics	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Number of community laboratory tests by provider	V	The no. of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services	DML = 349,007 LTA = 2,634,222	Ω Ω	October 2012- Sep 2013
Number radiological procedures referred by GPs to hospital	V	The no. of community referred radiological procedures is a direct indicator of the volume of output of community radiology diagnostic services	40,666	Ω	2012/13 (PU code CS01001)
Number of complaints by community laboratory provider ◈	Q	A high quality community laboratory diagnostic service will receive only a small number of complaints.	LTA = 60 DML = 29	↓	October 2012- Sep 2013
Average waiting time in minutes for a sample of patients attending collection centres between 7am and 11am	T	A high quality service will process patients quickly and efficiently, thereby avoiding long waiting times.	7.4 mins (LTA)	< 30 mins	October- December 2013
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	Timely access to diagnostic testing makes an important contribution to good patient outcomes.	CT 89% MRI 66%	CT 90% MRI 80%	December 2013

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

Output: Oral Health

Oral Health	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Enrolment rates in children under five by ethnicity: • Māori • Pacific • Other • Total population	C	Output is directly related to the proportion of children enrolled in the service	2,633-62% 4,194-73% 10,506-94% 22,107-74%	82%	2013 calendar year
Utilisation rates for adolescents	C	This is an indication of the volume of service in relation to the target population	64%	85%	2012 calendar year
Number of visits of preschool, and school children to oral health services (including adolescents)	V	Provides an indication of the volume of service.	79,233	n/a	2013 calendar year
Number of complaints in the financial year	Q	A high quality service will receive low numbers of complaints	11	↓	2013 calendar year
Arrears rates by ethncity: • Māori • Pacific • Other • Total population	T	A timely oral health service will have low arrears rates	9.6% 10.3% 8.2% 8.8%	Overall 7%	2013 calendar year

Output: Pharmacy

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Total value of subsidy provided.	V	This indicates the total DHB contribution towards patients' community drug costs.	128,436,885	Ω	2012/13
Number of prescription items subsidised	V	Another indicator of overall volume of community pharmacy subsidy to our population.	6,467,800	Ω	2012/13

Output Class 3: Intensive Assessment and Treatment

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

- Ambulatory services (including outpatient, district nursing and day services) across the range of hospital preventive, diagnostic, therapeutic, and rehabilitative services
- 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.

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

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 and suffering relieved with prompt service delivery, caring and courteous staff and comfortable, easily accessed facilities catering for all patients' needs.

Output: Acute Services

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Number of ED attendances	V	An indicator of the volume of emergency care provided to our population	112,846	Ω	2013
Acute WIES total (DHB Provider)	V	An indicator of the volume of acute hospital service provided to our population	91,898	95,328.8	2013
Readmission rates – acute readmissions within 28 days	Q	Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care	10.8% (75+) 7.92% (Total pop)	10.8% (75+) 7.92% (Total pop)	2013

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	Q	Emergency care is urgent by definition, long stays cause overcrowding, negative clinical outcomes and compromised standards of privacy and dignity	95%	95%	Q4 2013 /14
Compliance with shorter waits for cancer treatment national health target of all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy. (*becomes part of indicator reporting from October 2014 – no longer a health target)*	T	Ensuring timely access to cancer treatment for everyone needing it will support public trust in the health and disability system; and that these services can be used with confidence.	Chemo 100% Radiation 100%	100%	Q4 2013/143
Percentage of stroke patients thrombolysed.	T	Ensuring patients are treated promptly and appropriately improves health outcomes after stroke.	13.8%	6%	Q2 2013/14

Output: Maternity

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Number of births	V	An indicator of volume of service provide to our population	7380	Ω	2013 calendar year
Number of first obstetric consultations	V	An indicator of volume of service provide to our population	4573	Ω	2013 calendar year
Number of subsequent obstetric consults	V	An indicator of volume of service provide to our population	4136	Ω	2013 calendar year
Proportion of all births delivered by caesarean section	Q	An indicator of volume of service provide to our population	34.7%	↓	2013 calendar year
Established exclusive breastfeeding at discharge excluding NICU admissions	Q	A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge	75.8%	75%	2013 calendar year
Third/fourth degree tears for all primiparous vaginal births	Q	Women's Hospital Australasia (WHA) core maternity indicator: 3rd/4th degree tears major complication of vaginal delivery; significant impact on quality of life	5.1%	↓	2013 calendar year
Admission of term babies to NICU	Q	An indicator of intra-partum care	6.2%	↓	2013 calendar year
Number of women booking before end of 1st trimester.	T	An indicator of the degree to which services are accessible and equitably available. Early booking is associated with better maternal and foetal health outcomes.		↑	2013 calendar year

Output: Elective (Inpatient/Outpatient)

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Delivery of health target for elective surgical discharges	V	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)	12,982	13,872	2013/14
Number of first specialist assessment (FSA) outpatient consultations	V	FSA consultations are important component of our elective services output and the total number is a good indicator of the volume of our output	90,062	Ω	2013/14
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Q	Health Quality and Safety Commission (HQSC) defined	0.17	↓	Jan 2014
Percentage of respondents who rate their care and treatment as very good or excellent (ADHB only)	Q	Reflects the quality of the service	87.6%	90%	November 2013
Patients waiting longer than four months for their first specialist assessment (FSA)	T	Long waiting times for first specialist assessment causes people to suffer conditions longer than necessary, and therefore reflects poor timeliness of services	4.42%	0%	As at March 2014
Patients given a commitment to treatment but not treated within four months.	T	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.	5.67%	0%	As at March 2014

Output: Assessment Treatment and Rehabilitation (Inpatient)

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
AT&R bed days	V	Bed-days are a standard measure of the total output from this activity	35,589	Ω	2013/14
No. of AT&R inpatient events	V	A standard measure of the total output from this activity	1,926	Ω	2013/143
Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	T	This is an indicator of the timeliness of our AT&R service.	83%	90%	2013 calendar year

Output: Mental Health

Outputs measured by	Notes	Rationale			Baseline	Target 2014/15	Baseline Data
Improving the health status of people with severe mental illness							
Access to mental health services	C	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	Maori	4.92%	3.5%	Mar 2013/ Feb 2014
				Total	2.87%	3%	
			20-64	Maori	11.71%	7.5%	Mar 2013/ Feb 2014
				Total	3.93%	3.5%	
			Over 65	Total	3.76%	3%	Mar 2013/ Feb 2014

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Improving mental health services using transition (discharge) planning and employment					
Child and Youth with a Transition (discharge) plan.	Q	Youth discharge planning is directly linked to Rising to the Challenge, Drivers of Crime Initiative and the Youth Mental Health initiative.	New measure	95%	
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.					
% of clients seen within 3 weeks - Mental Health - Addictions % of clients seen within 8 weeks - Mental Health - Addictions	T	Waiting times for service are an indicator of timeliness.	 73.2% 96.5% 71.9% 90.6%	 80% 95%	2013 calendar year

Ω Demand driven forecast activity

Output Class 4: Rehabilitation and Support Services

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

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

By helping to restore function and independent living the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. 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 burden of institutional care costs to the health system.

Output: Home Based Support

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Total number of InterRAI assessments per month	V	Simple indicator of output of service	418 per month	450	Average per month over 2013
The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan	Q	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	94.5%	95%	interRAI assessment Q2 2013/14
Percentage of NASC clients assessed within 6 weeks	T	Long waiting times indicate poor timeliness of this service and can leads to poor outcomes and a poor service experience	100%	↑	2013 calendar year

Output: Palliative Care

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Total number of completed inpatient episodes of care (death or discharge) (ADHB only)	V	Inpatient hospice care is the main component off our expenditure on palliative care. Episodes or contacts measure the total output from this activity	777	Ω	2013 calendar year
Proportion of cancer patients admitted to hospice against proportion of cancer deaths by ethnicity - Māori - Pacific - Asian	C	Indicator of access equality. The percentage of cancer patients admitted to hospice care should reflect the percentage of cancer deaths by ethnicity.	Admits/ Deaths M 5% 7% P 11% 10% A 12% 8%	1:1	Admissions = 2012/13 2010 cancer death data
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	A well-functioning service should provide timely access for acute patients.	10.1%	↓	2013 calendar year

Output: Residential Care

Outputs measured by	Notes	Rationale	Baseline	Target 2014/15	Baseline Data
Total number of subsidised aged residential care bed days	V	Bed days are a standard measure of the volume of aged residential care service.	975,624	Ω	12 months to end of September 2013
Proportion of aged care providers with 4 year audit certification	Q	The granting of 4 year audit certification is a good indicator of on going confidence in the quality of care delivered by the facility.	25%	↑	February 2014
Percentage of NASC clients assessed within 6 weeks	T	Long waiting times indicate poor timeliness of this service	100%	↑	2013 calendar year

Module 4: Financial Performance

Financial management overview

Our financial goal is to remain financially sustainable well into the future. This is extremely challenging in the current environment and a significant savings plan is required for us to remain within budget for the next three years.

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

- 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.

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

- We have achieved a small surplus for this financial year of $0.3m. To achieve this year's result and maintain financial sustainability, we have continued to effectively manage Inter District Flow (IDF) revenue and expenditure, contain cost pressures across our services and successfully progress our business transformation and performance improvement initiatives. The savings target for 2013/14 of $74.4m is expected to be fully achieved; including unplanned savings that offset any that are no longer achievable
- The DHB incurred an unexpected downside in IDF wash-ups of $8.3mWithin the IDF casemix funded services there has been virtually no change in discharges but a 3% reduction in caseweights. The reduction in caseweights appears to be driven by fewer long stay and highly complex cases in cardiothoracic surgery, head and neck cancers, major trauma and neurosurgery. The trend may be natural variation or may continue into 2014/15. Should the trend continue, this will place further pressure on the Auckland DHB bottom-line in 2014/15
- No revaluation is planned for 2013/14. However a desktop revaluation has been undertaken indicating a significant movement in land values. We are currently undertaking a full revaluation for this asset class impacted.

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

We will continue to implement asset management improvement projects including looking after our current asset base by implementing appropriate upgrades, refurbishments, replacements and maintenance programmes using our free cash flow from depreciation. We will also use our limited available cash carefully to meet new facility, clinical equipment and technology investments to

support the growth in health services we provide to our population and those of other DHBs. Given limited capital envelope for the DHB sector (and indeed for most government sectors), we will continue to work and collaborate with our regional partners to ensure we are making the right capital investments in the right places at the right time.

Significant and serious steps have been taken to reduce costs at Auckland DHB over the 2012/13 and 2013/14 financial years. A comprehensive savings programme totalling $68m was successfully implemented in 2012/13 and in 2013/14 a savings programme of $74m is in place. The year-end result for 2013/14 includes $71.7m in savings. Further savings of just over $50m are built into the 2014/15 Annual Plan. This includes $39.5m savings for improvement initiatives, outlined in Module two of the Annual Plan. As well as the savings programme there has been a complete overhaul of the provider arm leadership structure for the organisation in 2014, with creation of sensible, more manageable directorates and clinical leaders as the single point of accountability. This is an enabler of sustainable ongoing system change required to meet health needs and live within the signalled funding path.

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 PBFF revenue for 2014/15 is based on the National Health Board funding envelope advice, with an increase of $19.64M or 1.82% per cent over the 2013/14 funding envelope (after rebasing adjustments). This includes a 0.61% ($6.57m) increase in contribution to cost pressures and 1.2% ($13.07m) for demographic growth.

Growth in IDF revenue for 2014/15 is, again, based on the National Health Board funding envelope advice, with an increase of $11.704m or 1.78% per cent over the 2013/14 funding envelope (after rebasing adjustments). This includes a 0.61% ($4.02m) increase in contribution to cost pressures and 1.15% ($7.596m) 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 PBFF funding increase will be of the same nominal value as that signalled for 2013/14 i.e. $19.64m. We have assumed that IDF revenue will increase by an average of the PBFF increase for our neighbouring regional DHBs, or 1.8%. We have assumed no service changes in respect to IDF revenue.

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

Expenditure Growth

Expenditure growth of $53.1m or 2.7% above the 2013/14 actual 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 2014/15 the combined growth of both our own Auckland population and the IDF population will result in an increase in workload above 2013/14 in the order of 1.6%. Demographic growth funding for our DHB for 2014/15 is allocated at 1.2%
- Impact on personnel costs of all settled employment agreements, automatic step increases, SMO 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 $27.3m or 3.4% over 2013/14 including bringing the Laboratory and Cleaning workforces in house $13.2m). Funding growth for cost pressures for 2014/15 is provided for at 0.61%. There are some $16.5m of planned savings included in this category
- FTE numbers for 2014/15 will grow in relation to the repatriation of workload from Diagnostic Medlab (67 FTE) and bringing the cleaning workforce in house (216 FTE). Other than these changes, FTE will remain at 2013/14 budget levels of circa 8,050 FTE. This will be necessary in order to produce the productivity improvements of around 3.0% which will be required in order to offset the cost impacts above and achieve a breakeven result.
- Clinical supplies growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. We estimate that the price impacts of these changes will be in the order of $3.1m or 1.3% over 2013/14. Costs also reflect the impact of growth in services provided by the DHB. We have included $11.5m of planned savings in this category. We continue to work with Health Benefits Ltd (HBL), Health Alliance supply chain teams and other national entities in order to realise around $7.8m of these benefits
- Infrastructure costs (not including interest, depreciation and capital charge) include a reduction for the outsourcing of cleaning $6.8m as a result of bringing the cleaning workforce in house. Cost growth in other lines in this category are based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. While these have resulted in increases we have been able to contain these costs by reductions in other costs in the same category. We have included $2.8m of planned savings in this 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 2014/15, overall performance improvement savings of $39.5m are planned. The Business Transformation Programme is described in Module 2 of the Annual Plan
- Impact of funder payment increases (not including IDF outflows which are as advised by the Ministry of Health) $26.8m including the following major changes (excluding IDF outflows):
    - Personal Health $21.0m: overall increase in price 0.6% ($2.6m) and demographic and IDF growth 1.3% ($8.8m). Regionally determined, Community Pharmaceuticals - per Pharmac

proposal $6.9m, PHO and GMS $1.2m, including Primary Care Initiatives $1.0m and register changes during 2013/14
    - Mental Health $3.1m: overall Increase in price 0.6% ($0.2m) and demographic and access growth 8.8% ($3.1m)
    - Disability Support (DSS) $0.5m: overall increase in price 0.6% ($0.8m) and demographic and access growth 1.6% ($2.3m) offset by reimbursements from MoH $2.6m previously treated as revenue
- Impact of interest rate gains made through the move to Westpac as the preferred supplier of banking services and generally lower market interest rates: $0.1m
- Outer Years Expenditure - as the revenue projection for outer years has largely been determined at National Health Board level, future expenditure levels have been reduced to align with funding growth levels. The funding gap is expected to continue to increase and this is planned to be covered by cost savings from the ongoing Business Transformation and Performance Improvement initiatives and a continued review of the services we provide and value added of these to improved patient outcomes.

Financial Risks

The achievement of the $39.5m savings from performance improvement initiatives is a challenge and the initiatives that will be most difficult to achieve are those involving system-wide design, review of skill mix, reconfiguring surgical services and sizing of tertiary services, teaching and training and national services to improve affordability. These initiatives will need to result in lower staffing costs, which is the most difficult area of cost to reduce.

Around $11.5m of the planned savings are currently categorised as difficult to achieve and work is underway to drive this risk down. It should be noted that in addition to the $39.5m performance improvement initiative savings, the plan contains built in efficiency assumptions around business as usual.

Forecast Financial Statements

The tables on the following page provide a summary of the consolidated financial statements for the audited result for financial year 2012/13, year-end actual but unaudited results for financial year 2013/14 and plans for financial years 2014/15 to 2017/18.

Statement of Comprehensive Income

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Government & Crown Agency Sourced	1,213,675	1,248,315	1,247,429	1,267,478	1,280,916	1,301,123
Non-Government & Crown Agency Sourced	81,702	84,224	97,391	99,147	101,328	103,557
IDFs & Inter-DHB Sourced	672,319	671,446	712,064	727,681	740,561	753,669
TOTAL FUNDING	**1,967,697**	**2,003,985**	**2,056,884**	**2,094,307**	**2,122,805**	**2,158,349**
Personnel Costs	770,142	805,100	832,425	849,240	860,547	878,658
Outsourced Costs	88,411	87,526	89,652	91,466	92,688	93,927
Clinical Supplies Costs	227,915	230,557	233,053	237,770	240,947	244,166
Infrastructure & Non-Clinical Supplies Costs	183,177	185,771	175,763	179,320	181,716	184,144
Payments to Providers	592,328	590,928	617,738	626,112	634,318	642,633
IDF Outfows	105,570	103,840	108,226	110,366	112,549	114,775
TOTAL EXPENDITURE	**1,967,543**	**2,003,722**	**2,056,857**	**2,094,275**	**2,122,765**	**2,158,304**
NET SURPLUS/(DEFICIT)	154	263	27	32	40	45
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	36,216		-	-	-	-
TOTAL COMPREHENSIVE INCOME	**36,370**	**263**	**27**	**32**	**40**	**45**

A commitment to financial sustainability is the basis for the planned breakeven financial performance indicated in the table above. However, the plans include stretched savings and revenue targets for 2014/15 which are also assumed to be sustainable to future years.

The forecast breakeven for 2014/15 and the continuation of these results for the period 2013/14 through to 2017/18 demonstrate the DHB's commitment and endeavour to contain costs in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

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

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

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Interest	17,698	16,326	16,356	16,356	16,356	16,356
Depreciation	40,531	40,354	41,911	45,329	48,362	51,028
Capital Charge	33,500	37,227	37,182	36,774	36,832	36,832
TOTAL FINANCING COSTS	**91,729**	**93,907**	**95,449**	**98,459**	**101,550**	**104,216**
% of Infrastructure & Non Clinical Supply Costs	**50%**	**51%**	**54%**	**55%**	**56%**	**57%**

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

Statement of Cashflows

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Cashflow from operating activities						
Cash was provided from						
MoH and other Government/Crown	1,894,264	1,919,931	1,960,836	1,995,160	2,021,477	2,054,792
Other Income	80,762	77,277	90,316	91,210	93,391	95,620
	1,975,026	1,997,208	2,051,152	2,086,370	2,114,868	2,150,412
Cash was applied to						
Payments for Personnel	(768,344)	(792,891)	(839,017)	(849,240)	(860,547)	(878,658)
Payments for Supplies	(419,783)	(406,786)	(392,099)	(406,842)	(410,383)	(414,432)
Capital Charge Paid	(33,819)	(37,227)	(37,182)	(36,774)	(36,832)	(36,832)
Net GST Paid	521	45	-	-	-	-
Payments to Providers	(694,823)	(694,768)	(725,964)	(736,478)	(746,867)	(757,408)
	(1,916,248)	(1,931,627)	(1,994,261)	(2,029,334)	(2,054,628)	(2,087,331)
Net Cash Flow from Operating Activities	58,778	65,581	56,890	57,035	60,240	63,081
Investing Activities						
Cash was provided from						
Interest Received	7,272	7,297	7,797	7,937	7,937	7,937
Proceeds from Sale of Fixed Assets	-	-	-	-	-	-
Decrease/(Increase) in Investments	(9,869)	(21,977)	(560)	-	-	-
	(2,597)	(14,680)	7,237	7,937	7,937	7,937
Cash was applied to						
Capital Expenditure	(36,025)	(35,972)	(92,219)	(69,958)	(67,212)	(48,665)
Net Cash (Outflow) from Investing Activities	**(38,622)**	**(50,651)**	**(84,982)**	**(62,021)**	**(59,275)**	**(40,728)**
Financing Activities						
Proceeds from Capital Raised/(Repaid) from the Crown	1,883	(2)	-	-	-	-
Proceeds from Loans Raised	1,846	84	199	(1,055)	(21)	-
Interest Paid	(16,344)	(16,326)	(16,356)	(16,356)	(16,356)	(16,356)
Net cash (Outflow) from Financing Activities	**(12,615)**	**(16,245)**	**(16,157)**	**(17,411)**	**(16,377)**	**(16,356)**
Net Cash Inflow/(Outflow)	**7,541**	**(1,314)**	**(44,249)**	**(22,397)**	**(15,412)**	**5,997**
Cash & cash equivalents at the start of the year	**89,578**	**97,119**	**95,805**	**51,556**	**29,159**	**13,747**
Cash & cash equivalents at the end of the year	**97,119**	**95,805**	**51,556**	**29,159**	**13,747**	**19,745**

Cash flow forecasts reflect the result of maintaining breakeven operating results. Breakeven operating results give rise to cash surpluses, essentially from the depreciation stream, which can be used to fund the capital projects approved by the Auckland DHB Board.

Statement of Financial Position

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
ASSETS						
CURRENT ASSETS						
Cash and cash equivalents	97,119	95,805	51,557	29,159	13,748	19,746
Trust/special funds	5,001	11,966	11,966	11,966	11,966	11,966
Debtors & other receivables	50,431	51,321	49,974	49,974	49,974	49,974
Prepayments	1,350	1,060	1,060	1,060	1,060	1,060
Inventories	12,884	12,267	12,267	12,267	12,267	12,267
	166,785	172,420	126,824	104,427	89,015	95,013
NON CURRENT ASSETS						
Trust/special funds	6,686	10,783	10,783	10,783	10,783	10,783
Property, Plant and Equipment	880,258	871,714	920,183	935,834	951,046	948,285
Intangible Assets	331	306	180	341	489	624
Derivatives financial instruments	1,072	722	-	-	-	-
Investment in joint ventures & associates	25,016	40,139	42,663	51,480	54,970	55,234
	913,363	923,664	973,810	998,439	1,017,289	1,014,926
TOTAL ASSETS	**1,080,148**	**1,096,083**	**1,100,634**	**1,102,866**	**1,106,304**	**1,109,939**
LIABILITIES						
CURRENT LIABILITIES						
Trade and other payables	119,182	123,082	134,521	137,777	141,195	144,785
Employee benefits	149,215	158,405	151,632	151,632	151,632	151,632
Interest-bearing loans & borrowings	12,761	82,670	12,869	11,814	11,793	11,793
	281,158	364,157	299,022	301,223	304,621	308,210
NON - CURRENT LIABILITIES						
Employee Benefits	23,369	25,844	25,501	25,501	25,501	25,501
Interest-bearing loans & borrowings	294,325	224,500	294,500	294,500	294,500	294,500
Patient & restricted trust funds	1,146	1,169	1,169	1,169	1,169	1,169
Derivatives financial instruments	-	-				
	318,840	251,513	321,170	321,170	321,170	321,170
TOTAL LIABILITIES	**599,998**	**615,670**	**620,192**	**622,393**	**625,790**	**629,380**
EQUITY						
Public Equity	576,798	576,797	576,797	576,797	576,797	576,797
Accumulated deficit	(483,601)	(483,337)	(483,308)	(483,276)	(483,236)	(483,190)
Other reserves	368,022	368,022	368,022	368,022	368,022	368,022
Trust/special funds	18,931	18,931	18,931	18,931	18,931	18,931
TOTAL EQUITY	**480,150**	**480,413**	**480,442**	**480,474**	**480,514**	**480,560**
NET ASSETS	**1,080,148**	**1,096,083**	**1,100,634**	**1,102,867**	**1,106,305**	**1,109,940**

The capital plan includes significant investments in IT assets transferred to healthAlliance and our continued investment in IT infrastructure and software via healthAlliance. A major component of this investment being $10.5m investment in the Windows 7 upgrade due to be completed by the end of 2014. In addition, the investment in Health Benefits Limited for the Finance Procurement and Supply Chain Programme will grow from $11.8m in 2013/14 to $12.4m in 2014/15 which will see an end of the planned investment in this programme.

Equity injections in 2012/13 reflect Crown funding for the Oral Health Project. The build-up of high levels of cash forecast for 2013/14 gives rise to the opportunity for further strategic investment. The intention to invest in capital spending is reflected in the planned cash flow projection. We currently have borrowing facilities with the Ministry of Health (MoH) of $254.5m, all of which have been drawn. We also have $50.0m in Bonds on issue until September 2015. The bonds will need to be refinanced by the Crown when they mature in September 2015.

Disposal of Land

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

Statement of Movement in Equity

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Balance at 1 July	**441,897**	**480,150**	**480,413**	**480,440**	**480,472**	**480,512**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	154	263	27	32	40	45
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	36,216	-	-	-	-	-
Total Comprehensive Income	**36,370**	**263**	**27**	**32**	**40**	**45**
Owner Transactions						
Capital Contributions from the Crown	1,883	-	-	-	-	-
Balance at 30 June	**480,150**	**480,413**	**480,440**	**480,472**	**480,512**	**480,557**

Asset revaluations as at 30 June 2013 have resulted in a $36.216m increase in building values, which will in turn increase the equity closing position in 2012/13. Equity injections for the Oral Health Project and a modest surpluses forecast for the 2013/14 and outer years improve the equity position.

Additional Information

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

Funding Arm Financial Performance

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Government & Crown Agency Sourced	1,136,813	1,167,689	1,167,405	1,186,476	1,198,355	1,218,451
Non-Government & Crown Agency Sourced	4,558	104	1,000	1,000	1,000	1,000
IDFs & Inter-DHB Sourced	651,980	656,392	697,020	712,354	725,177	738,230
Total Revenue	**1,793,351**	**1,824,185**	**1,865,425**	**1,899,830**	**1,924,532**	**1,957,681**
Expenditure						
Payment to Provider	**1,072,871**	1,104,963	1,128,482	1,146,538	1,158,004	1,176,532
Payment to Governance	**6,510**	5,639	10,975	11,173	11,374	11,579
	1,079,381	**1,110,602**	**1,139,457**	**1,157,711**	**1,169,378**	**1,188,111**
NGO Expenditure						
Personal Health	**426,317**	419,798	440,841	451,296	459,942	469,922
Mental Health	**30,601**	35,720	38,832	39,609	40,019	40,431
DSS	**134,033**	135,388	135,893	138,612	140,341	142,091
Public Health	**528**	1,034	1,100	1,115	1,140	1,150
Maori Health	**851**	344	1,076	1,096	1,114	1,126
	592,330	**592,284**	**617,742**	**631,728**	**642,556**	**654,720**
IDF Outfows	**105,570**	103,840	108,226	110,391	112,598	114,850
	697,900	**696,124**	**725,968**	**742,119**	**755,154**	**769,570**
Total Expenditure	**1,777,281**	**1,806,726**	**1,865,425**	**1,899,830**	**1,924,532**	**1,957,681**
Surplus / (Deficit)	**16,070**	**17,459**	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**16,070**	**17,459**	-	-	-	-

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 2014/15. As earlier observed, we estimate that for 2014/15 the combined growth of both our own Auckland population and the IDF population will result in an increase in workload above 2012/13 in the order of 1.6%.

For the purposes of the Statutory Accounts in 2012/13 the Laboratory and Procare contracts held by Auckland DHB on behalf of Waitemata and Counties Manukau DHBs were deemed to be agency agreements in terms of relevant Accounting Standards. On this basis, both revenue and expenditure were equally reduced by $143m. In 2013/14, 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.

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

Provider Arm Financial Performance

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Income						
MoH Base via Funder	**1,072,871**	1,104,963	1,128,482	1,146,538	1,158,004	1,176,532
MoH Direct	**51,103**	50,310	49,443	50,234	50,686	50,686
Other	**122,880**	129,143	142,017	144,573	147,568	150,623
Total Income	**1,246,854**	**1,284,416**	**1,319,942**	**1,341,345**	**1,356,258**	**1,377,841**
Expenditure						
Personnel	**763,505**	798,754	827,831	844,388	855,365	873,132
Outsourced Services	**87,523**	85,044	80,906	82,524	83,597	84,683
Clinical Supplies	**227,905**	230,557	232,930	237,589	240,677	243,806
Infrastructure & non clinical supplies	**175,407**	174,391	168,884	167,261	166,903	166,374
Other	**5,979**	10,597	9,364	9,551	9,676	9,801
Total Expenditure	**1,260,319**	**1,299,343**	**1,319,915**	**1,341,313**	**1,356,218**	**1,377,796**
Surplus / (Deficit)	**(13,465)**	**(14,927)**	**27**	**32**	**40**	**45**
Other Comprehensive Income						
Gains/ (Losses) on Property Revaluations	**36,216**	-	-	-	-	-
Total Comprehensive Income	**22,751**	**(14,927)**	**27**	**32**	**40**	**45**

Substantial improvements in productivity and cost effectiveness are planned in 2013/14. Savings targets of some $41.5m are included in the Provider Arm Plan above.

Governance and Funding Administration Arm Financial Performance

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Revenue from Funder Arm	**6,872**	5,639	10,975	11,173	11,374	11,579
Revenue Other	**-**	344				
	6,872	**5,983**	**10,975**	**11,173**	**11,374**	**11,579**
Expenditure	**9,323**	8,250	10,975	11,173	11,374	11,579
Surplus/ (Deficit)	**(2,451)**	**(2,267)**	-	-	-	-
Total Comprehensive Income	**(2,451)**	**(2,267)**	-	-	-	-

The Governance and Funding Administration arm continues to perform within the funding allocated, with a breakeven forecast in 2012/13 and the continuation of breakeven results planned throughout the planning period.

Capital Expenditure

The major components of 2013/14 Baseline Capital Expenditure planned are the Starship Theatre upgrade $5.8m, Lab Plus $7.7m, clinical fleet replacements $10.7m, building seismic strengthening $3.7m and facilities projects $18.8m. The balance is allocated for high priority clinical items: $26.6m.

In addition to the capital expenditure outlined above, Auckland DHB will continue to invest in IT infrastructure and software via its investment in Health Alliance. This part of our 2013/14 capital plan totals some $16.8m as outlined in the table on the following page.

Capital Expenditure

	2012-13 Audited $'000	2013-14 Actual $'000	2014-15 Plan $'000	2015-16 Plan $'000	2016-17 Plan $'000	2017-18 Plan $'000
Funding Sources:						
Free cashflow from depreciation	**40,531**	40,354	41,911	45,329	48,362	51,028
External Funding	**-**	-	-	-	-	-
Cash Reserves	**89,578**	97,119	95,805	51,556	29,159	13,747
Total Funding	**130,109**	**137,473**	**137,716**	**96,885**	**77,521**	**64,775**
Baseline Capital Expenditure						
Land	**-**	-				
Buildings and Plant	**13,042**	15,032	42,433	32,765	45,231	30,598
Clinical Equipment	**12,901**	14,273	38,888	29,204	19,587	15,745
Other Equipment	**840**	2,871	1,583	4,053	1,255	1,256
Information Technology (Hardware)	**700**	360	-	-	-	-
Motor Vehicles	**119**	2,524	500	446	875	875
Intangible Assets (Software)	**8,423**	912	8,817	3,490	264	191
Total Baseline Capital Expenditure	**36,025**	**35,972**	**92,220**	**69,958**	**67,212**	**48,665**
Strategic Investments						
Land	**-**	0	0	0	0	0
Buildings & Plant	**-**	0	0	0	0	0
Clinical Equipment	**-**	0	0	0	0	0
Information Technology	**-**	0	0	0	0	0
Intangible Assets (Software)	**-**	0	0	0	0	0
Total Strategic Capital Expenditure	**-**	-	-	-	-	-
Total Capital Payments	**36,025**	**35,972**	**92,220**	**69,958**	**67,212**	**48,665**

Banking Facilities and Covenants

Term Debt Facilities

We have term debt facilities of $254.5m with the Ministry of Health which are fully drawn and a public Bond issue of $50.0m repayable in September 2015. This is the last remaining private sector finance facility in place for Auckland DHB. We signal the need for these bonds to be refinanced by the Crown in September 2015 in line with the government policy for refinancing historical private sector debt with Crown debt. We will progress the application for appropriation allocation for this refinance with the National Health Board during 2014.

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 $4.0m for the sector. Auckland DHB is closing all previously arranged working capital facilities 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 Financing Agency), MBIA New York as insurer on behalf of the Bond holder, and the following banks; ANZ, BNZ, Westpac and CBA/ASB.

MODULE 5: Stewardship

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

Managing our Business

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

Organisational Performance Management

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

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

Risk Management

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

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

Asset Management

Asset Management Plan Development

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

Overall, the plan supports investment decisions by providing asset replacement profiles which facilitate management and ongoing maintenance of the current asset base as well as informing

future asset requirements to continue to meet the growing demand for health services provided by our DHB. The plan was last fully updated in 2011 including high level projections of how future health service demand would impact on Auckland DHB's asset base. Since then, the capital intentions underlying the plan have simply been updated annually to reflect known changes in asset states and short term capital intentions. It is intended to undertake a full Asset Management Plan update this year. However, this will require updated input from clinical service plans.

We continue to work towards incorporating principles of best practice asset management planning into our business-as-usual processes. The capital intentions signalled in our 2014/15 annual plan are informed by the longer term asset renewal and growth requirements identified in our Asset Management Plan. We have provided the Auckland DHB capital intentions to the National Health Board for the next ten years as part of the annual plan submission in March 2014. These mostly reflect our short to medium term capital priorities as well as the long term projects outlined in the Asset Management Plan. We have also provided information on our future capital intentions to the Northern Region Agency to help inform capital needs for the Northern region.

We are working collaboratively with Waitemata DHB on implementing best practice capital processes and business case development principles across our DHBs. During 2013/14, we developed joint capital related policies and procedures, aligning some of our capital planning, review and approval processes and practices. We also developed an investment manual that incorporates some of the NZ Treasury Better Business Case development principles. This will help us to make better inform capital and investment decisions. This will ensure that we are investing wisely, making the most of our limited capital funding to support the capital and infrastructure requirements of the health services we provide in line with the growing demand for these services.

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

- **Addressing Asset Data Integrity and Quality Issues:** Improving the quality of our asset data and related processes will better inform our capital needs and decisions
- **Clinical Equipment Asset Verification and Cataloguing:** We are planning to review and verify our clinical equipment with a view to creating a catalogue for high value clinical equipment assets with a value of $10,000 or more
- **Buildings Condition Assessments:** We have completed the high level condition assessments for all buildings owned by us as required by the Ministry's annual Asset Stock-take. The Asset Management Plan includes scheduled renewal of all major building and plant items (e.g. roofs, boiler and chillers) and the condition of these assets is regularly monitored by our Facilities Management. This is done by planned preventative maintenance checks scheduled in the BEIMS maintenance system, real-time monitoring of critical plant on the Building Management System and condition assessments undertaken by Facilities Management staff as major assets approach their scheduled renewal dates
- **Seismic Compliance Assessment:** We have been active in improving seismic compliance since 1999 when our Seismic Risk Management Plan (SRMP) was first prepared. Since then, a number of buildings have been exited, strengthened or demolished. In 2012 an update of the SRMP was undertaken to reflect new standards and engineering techniques. IEP analysis was undertaken for all major pre-1995 buildings. Out of this, only one additional structure (apart from those already identified) was found to be in need of strengthening and this is currently underway
- **Site Master Planning**: Work is on going around key strategic capital projects and timing of these in the medium to long term, including consideration of financing options for these. Clinical Services Planning information will be critical in determining the staging of all major facilities redevelopments to be included in the updated Site Master Plan and Asset Management Plan
- **Health Services Planning**: Health Services Planning remains a key outstanding work stream to inform the overall longer term asset requirements. Under the joint Funder arrangements with

our partner Waitemata DHB, a Director of Health Outcomes was appointed during 2013 and will be leading the development of a Health Services Plan for the two DHBs. The outcome of that work will further inform Site Master Planning and Asset Management Planning in terms of our future facility and capital requirements

- **Asset Management Plan Improvement Projects**: Key local Asset Management Plan improvement projects and regional considerations will be discussed in detail in the updated Asset Management Plan.

Emergency Planning

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

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

Building Capability

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, hospital 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 Regional Information Strategy (RIS 2010-20), and the Northern Region Information Systems Implementation Plan set the direction on information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for us to achieve our clinical and business objectives.

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

- Define the business requirements of the Northern Region DHBs in IS shared services
- Monitor the performance of IS shared services in line with regional priorities and requirements
- Prioritise the regional ICT programme of work, ensuring that resilience and security risks are appropriately addressed
- Provide strategic IS direction for the region
- Prioritise national, regional and local capital IS projects
- Monitor the performance of key projects.

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. The Northern Region DHBs began to address this in 2013/14 and this will continue in 2014/15, with investment in the following areas:

- Microsoft software upgrades in infrastructure
- Clinical and business systems upgrades to ensure systems can realise the potential available only in later versions

- On-going improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- Improved resilience and security of IS systems to improve system availability, access and data integrity.

Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and investment in our future systems. The regional plan also supports a five yearly computer replacement cycle to ensure these are regularly updated and fit for purpose.

In addition to the investment in core infrastructure and IS support processes, Auckland DHB and Waitemata DHB as part of the Northern Region will undertake the following activities with respect to key national and regional projects:

- G2012 Microsoft License Compliance
  - Upgrade of servers to Microsoft Windows 2008
  - Compliance with Department of Internal Affairs mandate around use of supported software
- NZ ePrescription Service (NZePS)/ CPSA
  - Implementation of the GP scripting service to access community pharmacies
- Maternity Clinical Information System
  - Regional support for Counties Manukau DHB as the lead Northern Region DHB to implement
- Hospital ePharmacy
  - Upgrade of the Auckland DHB ePharmacy system to enable multi-DHB use of the system and integration with the nationally mandated NZ Universal List of Medicines (NZULM) and NZ Formulary (NZF)
- Legacy Patient Administration System (PAS) Replacement ($331k)
  - Auckland DHB will take the regional lead on implementing a Northern Region PAS (plus EMR) with vendor selection and development and approval of the business case to be completed in this period
- eDischarge
  - the new national standard for eDischarge will be implemented across Auckland DHB and Waitemata DHB hospital services
- eMedicines Reconciliation (eMR) ($200k)
  - Auckland DHB will implement the Orion Health eMR module to enable implementation of eMedicines Reconciliation to hospital services
- eReferrals phases 2 and 3 ($251k)
  - Auckland DHB and Waitemata DHB will complete implementation of the eReferrals solution (including triage, intra and inter DHB referral functionality)
- Shared Care Planning ($300k capital expenditure for systems integration)
  - Auckland DHB and Waitemata DHB will continue implementation of the national shared care planning tool to support the management of complex, long term conditions and the localities joint initiative with the PHOs
- Clinical Pathways (337k)
  - Auckland DHB and Waitemata DHB will continue implementation of dynamic clinical pathways, and will also undertake static pathway development
- Mobility Adoption
  - Auckland DHB and Waitemata DHB will contribute to the development of a regional mobility strategy to guide our investment decisions and we will install WiFi infrastructure to provide coverage across key clinical and patient areas

Quality and Safety

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

In 2014/15 we want to move from a focus on incremental improvement to transformational change programmes. We are looking to embed quality improvement throughout the organisation, at a service level. We are committed to improving patient safety and the experience of our patients, working with our regional and sub-regional partners as well as the Health Quality and Safety Commission. We aim to build staff capability and capacity through a range of training programmes while strengthening our clinical governance structures and processes across the organisation. Specific actions are included in Module 2 'Patient Experience' and 'Quality'.

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

Workforce

Managing our workforce within fiscal restraints

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

Strengthening our workforce capacity

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

We will also work with their Regional Training Hub Director to develop and deliver a workforce plan as part of the 2014/15 Regional Service Plan. The workforce plan will outline regional actions and key milestones, which include General Practice Education Programme (GPEP2) requirements. On a case by case basis the DHB will work to develop placements to match individual GPEP2 trainee requirements. We will also work in partnership with professional leaders, primary care, professional bodies and unions to support and train increased numbers of diabetes nurse prescribers in the 2014/15 year. Auckland DHB currently has 6 nurse prescribers and will actively support at least 3 more nurses with the training required to prescribe. The DHB will support the growth of the medical workforce by aligning training funding to the 70/20/10 model to be implemented by July 2015.

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 to support the achievement of the Regional Health Plan objectives as well as local priorities and requirements. Te Runanga o Ngati Whatua will lead the development of an Auckland and Waitemata DHB Māori workforce strategy.

Strengthening our workforce culture

Our 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 work is underway to review and refresh our values and involve all our staff in it.

We will 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 processes 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 staff recognition and reward programmes will be implemented to reinforce the refreshed values and defined behaviours are being demonstrated in all areas of patient care and organisational activity. We will continue to develop a strong accountability framework through a single point of accountability, that being a clinician. Clinical leadership is at the core of all we do. Developing leadership capability is a key priority to drive and support change.

Our DHB will expand on the joint leadership work with Waitemata DHB and Professor Richard Bohmer and continue the leadership work with the New Zealand Leadership Institute. 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.

Auckland has historically provided a substantial proportion of the training posts available in New Zealand for all health professions. This is a very positive part of the culture of the organisation and is highly valued by trainees and training organisations. However, the direct and indirect costs of his level of provision are unsustainable in the current economic climate. We will therefore be evaluating the scope and method of provision of training and sizing it to meet the economic environment.

Safe and competent workforce

We will, as soon as practicable following Royal assent to the Vulnerable Children Bill, adopt and implement a child protection policy which will be reviewed every three years. The policy will be operationalised through service level agreements and a framework to help Auckland DHB community and hospital based staff identify and manage actual and/or suspected child abuse and neglect. In our Annual Report we will report on the extent to which we have implemented the policy. Our Abuse and Neglect policy and guidelines are available on our internet site.

We will review our recruitment policies and processes and implement amendments to comply with the safety checks being introduced in the Vulnerable Children's Bill to reduce the risk of harm to children. As required, we will introduce three yearly reassessments for existing employees within two years. The safety checking information about people employed or engaged by Auckland DHB in work that involves regular or overnight contact with children will be available for provision to the Director-General of Health.

Organisational Health

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

Our Good Employer policy makes clear that we will:

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

Reporting and Consultation

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

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

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

Ability to Enter into Service Agreements

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

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

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

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

MODULE 6: Service Configuration

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

Service Coverage and Service Change

Type of Service Change	Area impacted by Service Change	Description of Service Change
Configuration of services	Maternity Services	Consultation with the community and stakeholders will be undertaken regarding configuration of maternity services across the two DHBs and an implementation plan developed.
Service review and collaboration on service delivery	Women's Health Services	A formal collaboration project continues between Auckland and Waitemata DHBs which links with Counties Manukau DHB. The purpose of the collaboration is to review and inform the most appropriate models of care for primary and secondary maternity and gynaecology services across the Auckland region. Alongside this process, Auckland DHB is also reviewing all primary, secondary and tertiary women's health services to ensure that the models of care and resourcing align with population needs.
Funding change	Community Pharmacy	There will be changes in July regarding how DHBs pay Core Service Fees to pharmacy. However, this relates to funding rather than a service delivery change. Service users should not notice a change in care provision.
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 are piloting 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. This is a two year pilot, with a formal review in June 2014 and March 2015 which may result in further reconfiguration.
Change in model of service delivery	Mental Health NGO	We will continue our reconfiguration of residential rehabilitation services, from a residential model to a support hours model, where this will better meet client needs.
Level and configuration of services	Mental Health Services	Implementation of the recommendations from the regional review of both forensic high and complex service users and 'acute' high and complex service users that might result in service changes to meet specific needs.
Level and configuration of services	Mental Health Services	Completion of the Service Development Plan and Prime Minister's Youth Mental Health stocktakes and gap analyses. Meeting identified gaps may result in reconfiguration of contracts
Change in model of service delivery	Mental Health NGO	A regional review of youth residential services for metro Auckland may result in a reconfiguration of the current regional service into locally delivered services.

Type of Service Change	Area impacted by Service Change	Description of Service Change
Change in model of service delivery	Mental Health NGO	A regional review of the model of care for the regional Eating Disorders Service (contract holder Auckland DHB)
Configuration of services	Mental Health Services	Conversion of 3 CFU beds, to a 3 bed maternal mental health mother and baby unit, with a separate entrance.
Change in service location	Ophthalmology Services	Local service delivery in Waitemata district, by Auckland DHB, as a hub and spoke model, is planned to commence at Waitakere hospital as an outpatient and minor procedure service from July 2014. Further options for local service delivery to the Rodney area are being explored for commencement the 2014/15 year.
Level and configuration of services	Tertiary services	Continue to work with the National Health Board in the 2014/15 year to ensure a sustainable model for tertiary services.
Configuration of services	Health of Older People	Review of existing services to support the older person maintain independence in their home. Review will inform current service delivery and may change configuration of services in the future to improve integration of services across the sector.

MODULE 7: Performance Measures

Monitoring Framework Performance Measures

Performance measure	2014/15 National performance expectation/target			DHB Target	
PP6 Improving the health status of people with severe mental illness through improved access	**Age 0-19**	Māori		5.5%	
		Total		3.0%	
	Age 20-64	Maori		12.0%	
		Total		4.0%	
	Age 65+	Total		4.0%	
PP7: Improving mental health services using transition (discharge) planning and employment	Long term clients	Provide a report as specified			
	Child and Youth with a Transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan.		95%	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm				
	Age	<= 3 weeks	<=8 weeks	<= 3 weeks	<=8 weeks
	0-19	80%	95%	80%	95%
	Addictions (Provider Arm and NGO)				
	Age	<= 3 weeks	<=8 weeks	<= 3 weeks	<=8 weeks
	0-19	80%	95%	80%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1			0.95	
	Ratio year 2			0.90	
PP11: Children caries-free at five years of age	Ratio year 1			64%	
	Ratio year 2			65%	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1			85%	
	% year 2			87%	
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1			82%	
	0-4 years - % year 2			85%	
	Children not examined 0-12 years % year 1			7%	
	Children not examined 0-12 years % year 2			7%	
PP18: Improving community support to maintain the independence of older people	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan			95%	
PP20: improved management for long term conditions (CVD, diabetes and Stroke)					
Focus area 1: Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.				
Focus area 2: Diabetes Management (HbA1c) Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control			Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	

Performance measure	2014/15 National performance expectation/target	DHB Target
Focus area 3: Acute coronary syndrome services	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	70%
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	95%
Focus area 4: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
PP21: Immunisation coverage (previous health target)	Percentage of two year olds fully immunised	95%
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP25: Prime Minister's youth mental health project	Provide quarterly narrative progress reports against the local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth. Include progress on named actions, milestones and measures.	
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2014/15 and for any actions which are in progress/on going in 2014/15.	
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 40% lower than the average over the last 3 years	1.9 per 100,000
	Provide a quarterly report to the Ministry of Health with a root cause analysis of rheumatic fever cases and lessons learned	
PP29: Improving waiting times for diagnostic services	Coronary angiography – 90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	90%
	CT and MRI – a)90% of accepted referrals for CT scans and b)80% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	 90% 80%
	<u>Diagnostic colonoscopy –</u> a)75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) and b)60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)	75% 60%

Performance measure	2014/15 National performance expectation/target		DHB Target
	Surveillance colonoscopy 60% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		60%
PP30: Faster cancer treatment (details of expectations to be confirmed)	Proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days		85% (note becomes part of health target from Q2)
	Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat		100%
	Proportion of patients ready-for-treatment who wait less than four weeks for radiotherapy or chemotherapy		100% (note: becomes part of PP30 reporting from Q2)
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4		<95%
	Age 45-64		103%
	Age 0-74		<95%
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives		
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage		
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	an intervention rate of 21.0 per 10,000 of population	21 per 10,000
	cataract procedures	an intervention rate of 27.0 per 10,000	27 per 10,000
	cardiac surgery	DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.	6.5 per 10,000
	percutaneous revascularisation	a target rate of at least 12.5 per 10,000 of population	12.5 per 10,000
	coronary angiography services	a target rate of at least 34.7 per 10,000 of population	34.7 per 10,000
SI5: Delivery of Whânau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.		
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 3.18 days, which represents the 75th centile of national performance.	3.21 days
	Acute LOS	Maintenance of, or improvement on 2013 baseline performance	4 days
OS8: Reducing Acute Readmissions to Hospital	total pop		7.9%
	75 plus		10.8%
OS10: Improving the quality of identity data within the National Health Index (NHI) and	New NHI registration in error A. Greater than 2% and less than or equal to 4%		Greater than 1% and less than or equal to

Performance measure	2014/15 National performance expectation/target	DHB Target
data submitted to National Collections **Focus area 1: Improving the quality of identity data**	B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	3%
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%
	Validated addresses unknown Greater than 76% and less than or equal to 85%	Greater than 76% and less than or equal to 85%
	Invalid NHI data updates causing identity confusion	Still to be confirmed NOTE: this indicator will not be measured for at least Q1 and Q2 2014/15
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	Greater than or equal to 97% and less than 99.5
	National collections file load success Greater than or equal to 98% and less than 99.5%	Greater than or equal to 98% and less than 99.5%
	Standard vs edited descriptors Greater than or equal to 75% and less than 90%	Greater than or equal to 75% and less than 90%
	NNPAC timeliness Greater than or equal to 95% and less than 98%	Greater than or equal to 95% and less than 98%
Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD File Success Rate- Greater than 95%	Greater than 95%
	PRIMHD data quality	Routine audits undertaken with appropriate actions where required
Output 1: Mental health output Delivery Against Plan	Volume del*ivery for specialist Mental Health and Addiction services is within:* *a) five percent* variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV4: Improving patient experience	No performance target set	

MODULE 8: Appendices

Appendix 1: DHB Board and Management

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

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

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

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

Statement of accounting policies for the year ending 30 June 2015

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Auckland DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards have now been developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means Auckland DHB transitions to the new standards in preparing its 30 June 2015 financial statements. As the PAS have recently been developed, Auckland DHB has not yet fully worked through the implications of the new standards at this time.

These prospective financial statements have therefore been prepared under NZ IFRS. The DHB will work through the implications of the new standards during 2014/15. Due to the change in the Accounting Standards Framework for public benefit entities, all new NZ IFRS and amendments to existing NZ IFRS are not applicable to public benefit entities. The XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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, the Financial Reporting Act 1993 and the Crown Entities Act 2004. Auckland DHB is a Public Benefit Entity (PBE), as defined under NZ IAS 1.

Auckland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district. The consolidated financial statements include Auckland DHB and its subsidiaries and interest in associates and jointly controlled entities.

Auckland DHB's Corporate Address is:

Greenlane Clinical Centre,
214 Greenlane West,
Epsom,
Auckland 1051.

Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments, and interpretations issued but not yet effective that have not been 'early adopted', and which are relevant to Auckland DHB, are described below.

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as

those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply for PBEs before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Auckland DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Auckland DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Auckland DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Statement of compliance

The consolidated financial statements have been prepared in accordance with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). 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), local government bond stock, land and buildings.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

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

The estimates and underlying assumptions are reviewed on an on going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Judgments made by management in the application of NZ IFRSs that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 22.

Basis for consolidation

Subsidiaries

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

Subsidiaries are consolidated from the date on which control is obtained by the group and cease to be consolidated from the date on which control is transferred out of the group. In preparing the consolidated financial statements, all intercompany balances and transactions, revenue and expenses and profit and losses resulting from intra - group transactions have been eliminated in full.

Joint Ventures

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

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

healthAlliance N.Z. Limited is a joint venture company with Health 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

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

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

Associates

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

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

Northern Regional Alliance Limited is an associate with Counties-Manukau and Waitemata DHBs. It exists to support and facilitate employment and training for Resident Medical Officers across the

three Auckland regional DHBs and to provide a shared services agency to the four Auckland regional District Health Boards in their roles as health and disability service funders, in those areas of service provision identified as benefiting from a regional solution.

Foreign Currency

Both the functional and presentation currency of Auckland DHB and Group is New Zealand Dollars (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 the end of the reporting period are translated to NZD at the rate ruling at that date. Foreign exchange differences arising on translation and settlement are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the date the fair value was determined.

Budget Figures

The budget figures are those approved by the Board in its Annual Plan and included in the Statement of Intent tabled in Parliament. The budgets have been prepared using the same accounting policies as those used in the preparation of these financial statements.

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 PPE are as follows:

- Freehold land
- Freehold buildings and fit outs
- Plant, equipment and vehicles
- Leased assets
- Work in progress.

Owned Assets

Except for land and buildings, items of PPE are stated at cost, less accumulated depreciation and impairment losses.

Land and buildings are revalued to fair value as determined by an independent registered valuer with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every 3 years. The latest revaluation was done on 30 June 2014. Any increase in value of a class of land and buildings is recognised directly to other comprehensive income unless it offsets a previous decrease in value recognised in the surplus or deficit in which case the increase is recognised in the surplus or deficit. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the surplus or deficit.

Additions to PPE between valuations are recorded at cost.

Where material parts of an item of PPE have different useful lives, they are accounted for separately.

Disposal of PPE

Where an item of PPE is disposed of, the gain or loss recognised in the surplus or deficit 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. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at the inception of the lease, less accumulated depreciation and impairment losses. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Operating lease payments are recorded as an expense in the surplus or deficit on a straight-line basis over the lease term.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of PPE when that cost is incurred if it is probable that the future economic benefit embodied within the item will flow to ADHB. All other costs are recognised in the surplus or deficit as an expense as incurred.

Depreciation is charged to the surplus or deficit 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. The estimated useful lives of major classes of assets and resulting rates are as follows:

Asset Class	2014	2013
Freehold buildings and fit outs	1-89 years	1-89 years
Plant, equipment and vehicles	2-20 years	2-20 years
Leased assets	4-8 years	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 PPE on its completion and then depreciated. Work in progress balance includes both PPE and intangible assets.

Intangible Assets

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

Subsequent expenditure on computer software is capitalized only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates.

Amortization of computer software is charged to the surplus or deficit on a straight line basis over its estimated useful life. The useful life of computer software is calculated over 5 years (2013: 5 years) from the date that the software is available for use (refer Note 11b). Impairment losses are provided for on a continuing basis as required.

Auckland DHB makes payments to Health Benefits Limited (HBL) in relation to the Finance, Procurement and Supply Chain (FPSC) Programme. The FPSC Programme is a national initiative, facilitated by HBL, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

HBL has issued B Class Shares to DHBs for the purpose of funding the development of the National Finance, Procurement and Supply Chain Shared Service. The following rights are attached to these shares;

Class B Shares confer no voting rights

Class B Shareholders shall have the right to access the Finance, Procurement & Supply Chain Shared Services

Class B Shares confer no rights to a dividend other than that declared by the Board and made out of any net profit after tax earned by HBL from the Finance, Procurement and Supply Chain Shared Service

Holders of Class B Shares have the same rights as Class A Shares to receive notices, reports and accounts of the Company and to attend general meetings of the Company

On liquidation or dissolution of the Company, each Class B Shareholder shall be entitled to be paid from surplus assets of the Company an amount equal to the holder's proportional share of the liquidation value of the Assets based upon the proportion of the total number of issued and paid up Class B shares that it holds. Otherwise each paid up Class B Share confers no right to a share in the distribution of the surplus assets. This payment shall be made in priority to any distribution of surplus assets in respect of Class A Shares.

On liquidation or dissolution of the Company, each unpaid Class B Shares confers no right to a share in the distribution of the surplus assets.

The rights attached to the "B" Class share include the right to access, under a service level agreement, shared services in relation to finance, procurement and supply chain services and therefore, the benefits conferred through this access. The service level agreement will contain five provisions specific to the recognition of the investment within the financial statements of the NMDHB. The five provisions are:

The service level agreement is renewable indefinitely at the option of the DHBs; and

The DHBs intend to renew the agreement indefinitely; and

There is satisfactory evidence that any necessary conditions for renewal will be satisfied; and

The cost of renewal is not significant compared to the economic benefits of renewal; and

The fund established through the on-charging of depreciation by HBL will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

The application of these five provisions means the investment, upon capitalization on the implementation of the FPSC Programme, resulting in the asset being recognised as an indefinite life intangible asset.

Interest-Bearing Loans and Borrowings

Interest-bearing capital borrowings are initially recognised at fair value net of transaction costs that are directly attributable to the issue. After initial recognition, capital borrowings are measured at amortized cost using the effective interest method. Amortized 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. Fair value movements are recognised in the surplus or deficit.

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

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

DHB Bond FRAs

Auckland DHB entered into a Bond Forward Rate Agreement (FRA) with Westpac Bank on 3 August 2012. This was to hedge the exposure to rising interest rates in future.

Each year, the fair value of the Bond FRA is recognised in the accounts.

Trade and other receivables

Trade and other receivables are recognised and carried at amortised cost amount less impairment. Impairment is calculated in accordance with the Board's credit management policy. 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 realizable value. Net realizable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses. Standard costs are reviewed at least once a year and revised in the light of current conditions as required. 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 3 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 surplus or deficit.

Financial instruments

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

A financial instrument is recognised if Auckland DHB becomes a party to the contractual provisions of the instrument. Financial assets are de-recognised if Auckland DHB's contractual rights to the cash flows from the financial asset expire or if Auckland DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular purchases and sales of financial assets are accounted for at trade date i.e. the date that Auckland DHB commits itself to purchase or sell the asset. Financial liabilities are de-recognised if Auckland DHB's obligations specified in the contract expire or are discharged and cancelled.

Restricted trust funds are initially recognised at cost, being the fair value of the consideration given. After initial recognition, these investments are classified at fair value through the surplus or deficit and are measured at fair value.

Gains or losses on restricted trust funds are recognised in the surplus or deficit.

Employee benefits

Defined Contribution Plan (DCP)

Obligations for contributions to DCPs are recognised as an expense in the surplus or deficit as incurred. ADHB makes contributions on behalf of staff to the National Provident Fund which is recognised in the surplus or deficit as incurred - see disclosure note 13d.

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 ADHB 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 3 years non-vesting entitlement under the current collective agreement with Senior Medical Officers based on current leave patterns.

Provisions

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

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. Future operating costs are not provided for.

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.

In accordance with Generally Accepted Accounting Practice and NZ IFRS, surpluses of Income over expenditure are reported through the Statement of Financial Performance. Where such surpluses are in respect of Mental Health Ring Fenced Revenue, the unspent portion of the revenue is only available to be spent on Mental Health Services in subsequent accounting periods.

Trust and special fund donations received are treated as revenue on receipt, in the surplus or deficit. These funds are administered by the Auckland District Health Board Charitable Trust. Trust and special funds from third party trusts are recognised as revenue only when actually receipted.

Interest income is recognised using the effective interest method.

Lease Expenses

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Leases where Auckland DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Goods and Services Tax (GST)

All amounts are shown exclusive of GST, except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Borrowing Costs

Borrowing costs are recognised as an expense when incurred.

Change in accounting policies

There have been no changes in accounting policies during the financial year.

Glossary

ACC	Accident Compensation Commission
ADHB	Auckland District Health Board
ALOS	Average Length of Stay
AOD	Alcohol Other Drugs
ARDS	Auckland Regional Dental Service
ASH	Ambulatory Sensitive Hospitalisations
BSA	Breast Screen Aotearoa
CADS	Community Alcohol, Drug and Addictions Service
CAMHS	Child, Adolescent Mental Health Service
COPD	Chronic Obstructive Pulmonary Disorder
CT	Computerised Tomography
CVD	Cardiovascular disease
DNA	Did Not Attend
DSME	Diabetes Self Management and Education
EBI	Effective Brief Intervention
ENT	Ear, Nose and Throat specialty
ESPI	Elective Services Performance Indicators
FSA	First Specialist Assessment (outpatients)
FTE	Full Time Equivalent
GNS	Gerontology Nurse Specialist
GP	General Practitioner
HOP	Health of Older People
ICU	Intensive Care Unit
LMC	Lead Maternity Carer
LTC	Long Term Conditions
Manawhenua	Iwi of the region with Trusteeship of Land
MHP	Māori Health Plan
MoH	Ministry of Health
MOU	Memorandum of Understanding
NCSP	National Cervical Screening Programme
NIR	National Immunisation Register
NRA	Northern Region Alliance (NoRTH and Northern Region DHB support Agency)
NSH	North Shore Hospital
OIS	Outreach Immunisation Service
ORL	Otorhinolaryngology (ear, nose, and throat)
PAM	Potentially Avoidable Hospital Admissions
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care

PPP	PHO Performance Programme
Q1 Q2 Q3 Q4	Quarters 1-4, ie by 30 September, 31 December. 31 March or 30 June
RACIP	Residential Aged Care Integration Programme
RFP	Request for Proposal
SIA	Services To Improve Access
SME	Self Management Education
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention.
WCTO	Well Child / Tamariki Ora
Whānau	Extended family
Whānau Ora	Families supported to achieve their maximum health and wellbeing
WTK	Waitakere Hospital
YTD	Year To Date

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai