AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

2020/21 Annual Plan

Incorporating the 2019/20-2022/23 Statement of Intent and 2020/21 Statement of Performance Expectations

Auckland District Health Board

Te Toka Tumai

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Mihimihi

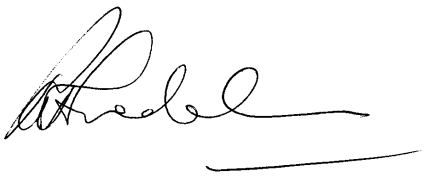
E ngā mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā koutou katoa
Ki wā tātou tini mate, kua tangihia, kua mihia kua ea
Rātou, ki a rātou, haere, haere, haere
Ko tātou ēnei ngā kanohi ora ki a tatou
Ko tēnei te kaupapa, 'Oranga Tika', mō te iti me te rahi
Hei huarahi puta hei hāpai tahi mō tātou katoa
Hei Oranga mō te Katoa
Nō reira tēnā koutou, tēnā koutou, tēnā 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 tētahi atu ki waho
Te Tihi Oranga O Ngāti Whātua"

The Auckland District Health Board Annual Plan for 2020/21 is signed for and on behalf of:

Auckland District Health Board
Te Toka Tumai



Pat Snedden
Chair

William (Tama) Davis
Deputy Chair

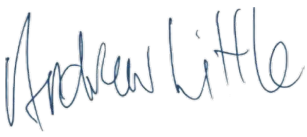
Ailsa Claire
Chief Executive

Northern Iwi-DHB Partnership Board

Gwen Tepania-Palmer

Chair

And signed on behalf of:
The Crown



Hon Andrew Little
Minister of Health

Date
18 December 2020

Hon Grant Robertson
Minister of Finance

Date
18 December 2020

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Pat Snedden
Chair
Auckland District Health Board
sned.pub@gmail.com

18 DEC 2020

Tēna koe Pat

Auckland District Health Board 2020/21 Annual Plan

This letter is to advise you that we have approved and signed Auckland District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

We are pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

We are disappointed with your significant planned deficit position and agree to approve your DHB's Plan on the basis that it is a maximum anticipated deficit.

We expect that the DHB will:

- provide a verbal update to the Ministry of Health on the local governance and operational arrangements in place to ensure better financial performance management including financial controls, probity, compliance, reporting and scrutiny processes, at your next performance meeting

- provide a written report confirming these local assurance arrangements as part of quarter two reports due with the Ministry in January 2021.

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your performance is consistent with the agreed plan.

We particularly encourage you to ensure that your senior executives maintain the tight fiscal controls and implement planned service improvements that will be necessary to sustain financial performance in the out years. Good financial performance allows us to invest more in new models of care, both in hospitals and the community, improve population prevention, and to invest in better health assets.

The Ministry will have engaged with the DHB on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. If your DHB has not done so already, we encourage you to accept offers from the Ministry to utilise this funding.

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Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

We look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Ailsa Claire
Chief Executive

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SECTION 1: Overview of Strategic Priorities

Foreword from our Chairman and Chief Executive

When we first wrote the foreword for the Annual Plan, who could have predicted what has happened this year with the COVID-19 pandemic.

It has been a time of anxiety for everyone in New Zealand, including the people working in health.

Our response to COVID-19 saw our Auckland DHB people at their best. We had to change rapidly and respond to an evolving situation. Our people embraced those changes and went above and beyond.

Together, with primary care partners, NGOs and Māori and Pacific health communities, our hospitals were prepared for the worst, community testing centres were rapidly set up, laboratory capacity was increased, screening programmes and contact tracing were put in place. There was also a unique Māori and Pacific lens to ensure we provided information and access to help in a way that worked.

The planning for COVID-19 meant that some of the things we planned to do as a DHB were paused and other things were very rapidly implemented.

As we continue to live with the impact of COVID-19 we have a chance to reset. Our new normal is an opportunity to think about how we might do things differently.

Meeting our obligations under Te Tiriti o Waitangi and improving health outcomes for Māori continues to be at the core of what we do. This year, we will partner with Iwi to develop a Māori health equity plan. This will be monitored and led by the recently formed Northern Iwi-DHB Partnership Board.

We know there are barriers to achieving equitable outcomes, particularly for Māori and Pacific people.

We have already made progress in some of our services, including mental health, cancer, child health and women's health.

This coming year will be one of transition as we examine our services and their delivery to ensure equity is at the foundation of all that we do.

There is more to do to continue to meet the health care needs of our population within budgets available. One of the ways we will achieve this is to continue to work more closely with the Northern Region DHBs to implement the Northern Region Long-Term Health Plan.

It will be a year to try new things, so we can continue to deliver world-class healthcare for all and support all of our communities to be healthy.

We will do this in partnership and with the continued commitment and professionalism of our Auckland DHB people.

Pat Snedden

Chair, Auckland District Health Board

Ailsa Claire OBE

Chief Executive, Auckland District Health Board

Message from the Chair of our Iwi-DHB Partnership Board

Kupu Whakataki

A word from the Northern Iwi-DHB Partnership Board Chair, Ms Gwen Tepania-Palmer

E nga iwi, e nga karangatanga maha, tena koutou.

E nga mate kua mene ki te po, haere, haere,haere.

Ka huri matou ki te hunga ora, tena koutou katoa

Nga mihi maha hoki ki a koutou

Tena koutou, tena koutou, tena koutou katoa.

The Northern Iwi-DHB Partnership Board is a Tiriti-based partnership between DHB Chairs and Iwi Chairs that aims to both focus attention and resources on achieving Māori health equity at all levels of the health sector, as well as to improve oversight by Māori and accountability for these activities. We are driven to achieve Māori health outcomes by empowering iwi to participate in a genuine partnership with the three northern-most DHBs.

The unjust, unfair and avoidable health inequities that Māori and other vulnerable members of our communities experience are not acceptable. This is our stance as a Partnership Board, and we are heartened to see this reflected at all levels of the organisation through the actions captured in the Annual Plan 2020/21.

This coming year will be a historic year for all of us. We will carry out the actions of this plan under the shadow of COVID-19. As a sector, as a community, and as Te Tiriti o Waitangi partners, we responded to the outbreak and will continue to work together to enhance the wellbeing of our communities and workforce. During the early months of 2020, our partnership was tested. I chaired my first partnership meeting with iwi during Alert Level 4 to support their response to the COVID-19 outbreak. As a result, I believe our partnership is stronger now.

On behalf of the Partnership Board, I look forward to seeing the actions in the Annual Plan progress over the next 12 months and beyond.

Na reira, Ka nui te Ora

Gwen Tepania-Palmer

Chair, Northern Iwi-DHB Partnership Board

Introduction

Auckland DHB is the Government's funder and provider of health services to the estimated 494,000 residents who live in the Auckland isthmus, Waiheke Island and Great Barrier Island.

Our population is diverse and rapidly growing. Just over 8% of Auckland residents are Māori, 11% are Pacific, and 33% are Asian. Around 46% of our population were born overseas. Our Asian population is proportionally our fastest growing population, and is projected to increase to nearly 40% of the total in the next ten years.

Auckland's population is generally healthier than that of New Zealand as a whole. We have the one of the highest life expectancies in New Zealand at 82.9 years, with an increase of 2.7 years since 2001.

Auckland DHB operates the largest teaching hospital and research centre in New Zealand. We provide many highly specialised services to the whole country.

Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. We also provide community child and adolescent health and disability services, community mental health services and district nursing.

Close to 12,000 people are employed by Auckland DHB. In 2020/21, we have a budget of $2.6 billion.

DHBs act as planners, funders and providers of health services, as well as owners of Crown assets. Our Planning, Funding and Outcomes Division is responsible for assessing our population's health needs and determining the range of services to be purchased within the available funding constraints.

As Auckland's largest business, we endeavour to positively impact the local economy and environment, and support our people to achieve the health outcomes they want.

We need to be increasingly flexible with how we focus and prioritise our resources alongside a more integrated, collaborative health system led by the four Northern Region DHBs to support our population to optimise their health outcomes.

Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus within our district. The identified needs are balanced alongside national and regional priorities.

These processes inform the Northern Region Long-Term Health Plan (NRLTHP), which sets the longer-term priorities for DHBs in the northern region, the annual Regional Services Plan and this Annual Plan.

This Annual Plan articulates Auckland DHB's commitment to the expectations of the Minister of Health, and to our Board's vision of **healthy communities, world-class healthcare, achieved together**. Kia kotahi te oranga mo te iti me te rahi o te hāpori.

Our plan details the key activities identified by the Minister for delivery in 2020/21. There is a strong focus on improved performance and access, financial sustainability, health equity and service performance to meet legislative requirements. A renewed Statement of Intent (SoI) is not required for 2020/21; we have therefore only made minor updates to our SoI, presented in Appendix A.

2020/21 year will be a time of transition

In 2019/20, we advanced several strategic work programmes that helped us to mitigate risk, prepare for future challenges and meet our regional contribution to the NRLTHP.

Our strategic priorities are to meet our obligations under Te Tiriti o Waitangi. This will require significantly more attention and resource. We also need to deliver equitable outcomes, both for Māori and Pacific, in order to remedy past underservice to these communities. Key to this work is maintaining focus on identifying and dismantling systems, structures and practices that directly or indirectly amount to racism.

Other significant pieces of work will take effect in 2020/21. The way we work needs to change to allow us to move more quickly. Our COVID-19 response work has demonstrated that we can organise ourselves as a sector and across sectors to deploy resources where they are critically needed. In order to realise the gains from this work and to keep pace with change, we have decided to concentrate our effort in the shorter term around a tighter set of realistic and achievable strategic priorities.

A new strategic plan will take effect in 2020/21, setting the direction to 2023. The strategy will articulate the work programme and operating model we need to deliver results for iwi, Māori, for Pacific communities and for patients and whānau.

More detailed discussion of our strategy and detailed reporting, including Financial Performance and the Statement of Performance Expectations for 2020/21, is contained in the appendices.

Equity

While our population is diverse, the health status of the majority of our population is very good and we are a relatively affluent population. However, Māori and Pacific communities experience inequalities in health outcomes and we have identified ethnicity as the strongest equity parameter. In addition, one in five (18%) of our total population, 27% of our Māori population and 40% of our Pacific population live in areas ranked as highly deprived (NZDep13). These areas are mainly in eastern areas from Glen Innes south to Mt Wellington and Otahuhu.

We know that Māori and Pacific people in our district have poorer health status than Pakeha, a result in part, because of underservice and failures in our system. Māori are guaranteed rights under Te Tiriti o Waitangi which means attention to our Treaty obligations as a Crown entity is paramount to securing Māori health gain. We prioritise health gain for Māori based on the rights that Māori hold as tangata whenua.

Our Board, iwi and other stakeholder organisations are identifying the activities needed to drive change. 2020/2021 will be a year of considerable transition as we interrogate our services and practices to make equity synonymous with quality and our foundation.

In 2020/21, our key priorities for equity are to:

- enact Treaty responsibilities to protect Māori rights as tangata whenua
- reorganise our systems and practices to address institutional barriers and racism
- achieve equitable outcomes for Māori
- bring Māori health gain and equity to the forefront of everything we do
- achieve equitable outcomes for Pacific.

We are developing strong relationships across the sector focused on health equity. Collaboration with our iwi and stakeholders will allows us to offer whānau-centric, comprehensive and holistic models of care. Our provider reinforces our equity agenda to improve support for our lower income employees, increase our employment of Māori and Pacific, and mandate specific services to accelerate health gains for our community.

The Ministry of Health is developing a new Māori Health Action Plan in response to the substantial challenges in achieving equitable health outcomes for Māori. The first part of Section 2 of our Annual Plan identifies our actions in furthering this work.

We are committed to eliminating inequity for Pacific peoples. We are reviewing our systems to find barriers that deny our Pacific equitable access. We have already made progress through work in DNAs, cancer, mental health, child health and women's health. Service changes in bariatrics showed real benefits for Pacific patients and fanau. In 2020/21, we will enable other directorates to reorganise service delivery to achieve equity.

We have a commitment to the principles of the United Nations Convention on the Rights of Persons with Disabilities and are guided by national strategies, including: He Korowai Oranga (Māori Health Strategy), Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan, and the Healthy Ageing Strategy.

Te Tiriti o Waitangi

The 2019 Waitangi Tribunal Hauora Report reinforced the need for the Crown to recognise and provide for Te Tiriti o Waitangi and its principles, and to commit the health sector to achieve equitable health outcomes for Māori.

Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti that established Māori as equal partners with the Crown. The four Articles of Te Tiriti provide a framework for developing a world-class health system that honours the beliefs and values of Māori patients, that is responsive to the needs of Māori communities, and achieves equitable health outcomes for Māori.

We recognise the importance of our Memoranda of Understanding (MOU) partner, Te Rūnanga o Ngāti Whātua, in the planning and provision of healthcare services to achieve this system and Māori health gain.

Article 1 – Kawanatanga (governance)
Partnership, trust and shared decision making
We will ensure Māori oversight and ownership of decision-making processes necessary to achieve Māori health equity. Active partnerships built on trust and mutual respect with iwi and Māori communities will ensure that Māori knowledge informs and drives the work that we do for Māori health gain.

Article 2 – Tino Rangatiratanga (self-determination)
Mana motuhake, Māori leadership and options
Māori leadership across the services we provide and fund is essential for a system that gives expression to tino rangatiratanga. An important component of this is supporting Māori to own and operate health services that are underpinned by their tikanga and world views, and give whānau choice to access the very best care that is aligned to their values, needs and aspirations.

Article 3 – Oritetanga (equity)
Māori health equity, justice and action
We are committed to ending unjust and unfair Māori health inequities by resourcing actions that achieve

tangible health outcomes for whānau Māori. We will be bold and support Māori knowledge to inform and embed an equity driven workforce and culture at all levels of our organisation.

Article 4 – Te Ritenga (right to beliefs and values)
Active protection, cultural safety and value-driven

We will actively protect and honour the beliefs and values of Māori patients, staff and communities. Moving our workforce towards Māori cultural safety is one aspect of this work, while another is supporting Māori staff members, and whānau who access our services, to feel safe to express and share their culture within our organisation.

Our strategy for health, wellbeing and equity

Our job as a district health board is to set the health, wellbeing and equity imperatives for our people and communities, set clear and achievable work programmes, and deliver health and disability outcomes. Our local actions support our region and the whole health sector to achieve national health goals.

Our vision for the Auckland district is Kia kotahi te oranga mo te iti me te rahi o te hāpori: healthy communities, world-class healthcare, achieved together. This commits us to ensure the best possible health and wellbeing for people, whānau, iwi and communities, and all those who rely on our health and disability services. Our vision translates to three **strategic outcomes**, which are the key priorities we want to achieve over the longer term:

Healthy communities	Achieving the best, most equitable health outcomes for Auckland communities
World-class healthcare	Ensuring that people receive reliable, equitable, high quality, safe and empowering support when they need it
Achieved together	Working as one system with practitioners, patients, iwi, whānau, communities, and other sectors

The DHB vision is supported by a set of values that reflect our culture and the way we work:

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

Further detail on our strategic direction is contained in our Statement of Intent, in Appendix A.

Key areas of immediate focus for 2020/21

2020/21 will be a time of transformation as we concentrate activity on Māori health outcomes and equity work. We have a development programme in preparation for this and our other strategic priorities. Our local and regional response work during COVID-19 underscored the importance of flexibility, adaptability and rapid decision making. Given the rate of change still ahead of us, we need an operating model that enables us to keep pace. We have strategic priorities to deliver by 2023 and are drawing on agile and similar change methodologies to help us deliver results more quickly.

Our biggest challenges regarding Māori health and equity work include to: determine our governance and operational arrangements with iwi; specify the activities that deliver on our Te Tiriti o Waitangi obligations and those that address equity; interrogate our DHB structures and processes for racism; record and track ethnicity and performance data across core activities; assign accountabilities for achieving outcomes; and ensure we have the internal capacity and capability to deliver results. We need to strengthen the partnerships required to deliver results for Māori and ensure funding is re-directed towards health gain. Achieving Pacific health gain will also require stronger connections with active Pacific providers in our communities and a reorientation of provider services to prioritise Pacific outcomes.

The development work acknowledges that our DHB has some deeply entrenched problems that will take time to remedy. Quick fixes are not possible in a large-scale social justice programme of work. However, we cannot let this complexity become an excuse for inactivity. For this reason, we have work underway via key programmes:

- 3-year approach for Planned Care, including actions to understand and address inequities for Māori
- Improving Māori health outcomes in cancer services
- Māori health plans developed for key services
- Regional work for Pacific equity including emergency response work within Public Health.

The starting point for each directorate within the provider is a review of their collection and analysis of ethnicity data. Services cannot design new pathways of care until they understand the patterns of admission for groups, and identify barriers in existing pathways. The first step is to develop more sophistication in ethnicity recording, analysing and tracking.

To date, considerable work has been done in the area of missed appointments: Did Not Attend (DNA) and Was Not

Brought (for children's health). The culmination of this work is an evidence-based strategy to reduce DNA rates. This four-stage plan was piloted in some areas with good results. Since the development of that strategy, we now see DNAs as our system failure to attract patients to our services i.e. Did Not Attract.

During the COVID-19 outbreak, the Northern Regional Health Coordination Centre demonstrated how well we can address health protection, social, welfare and cultural needs in a crisis. Both the Māori response team and Pacific response team were successful in managing the COVID-19 outbreak by working regionally, drawing in community leaders and providers, and staying firmly grounded in cultural practice.

While some of our pilot work and innovations demonstrate good outcomes for Māori, there is no additional resource to support this work. Our equity work requires new investment and the funding needs to be re-allocated from lower value activities. We are working on a prioritisation process that is fair and transparent, based on principles agreed by the Board, management and iwi.

Please see the 'Improving Sustainability' part of Section 2 below which identifies out-year planning activities that support system sustainability.

National, regional and sub-regional strategic direction

Auckland DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and aligns with the health and disability system outcomes framework and the New Zealand Health Strategy. The actions detailed in Section 2 of this plan align to the Minister's expectations and the Government's priority outcomes.

The NRLTHP (previously Northern Region Long Term Investment Plan – NRLTIP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed and updated to form the NRLTHP. The annual Regional Services Plan will be developed from this and reflect the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement in 2020/21.

Auckland and Waitematā DHBs have a bilateral agreement that joins governance and some activities.

Furthermore, collaboration across the Northern Region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and healthcare outcomes, and reduce duplication.

Strong clinical leadership is embedded at all levels of the organisation, enabling us to advocate for the health of our local population. We work with our District Alliance groups and other stakeholders to ensure a whole-of-system approach, working towards better integrated services and improved patient experience.

Regional and national networks with strong clinical leaders support work at both regional and national levels and focus DHB contribution to regional and national programmes.

Improving health outcomes for our population

Auckland DHB's performance framework demonstrates how the services we fund or provide contribute to the health of our population and achieve our long-term outcomes and the Government's expectations.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government priorities.

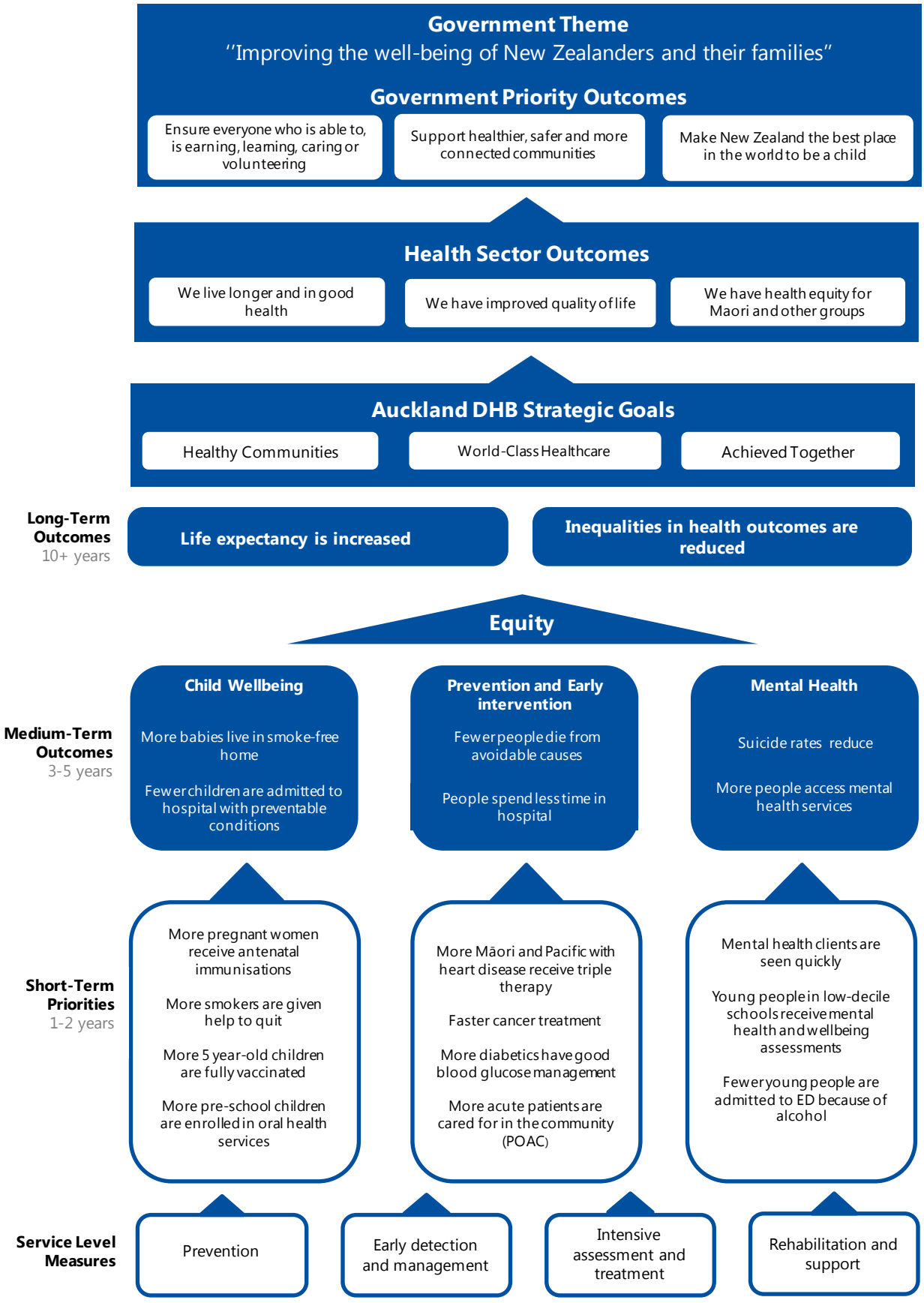
We have two overall long-term population health outcome objectives: life expectancy at birth continues to increase; and inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

The outcome measures are long-term indicators; the aim is for a measurable change in health status over time, rather than a fixed target.

Our medium-term outcome goals and short-term priorities will support achievement of these overall objectives. Our medium-term outcomes define our priorities for the next 3 to 5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. Local progress against these indicators will be tracked throughout the year.

The Statement of Performance Expectations (Appendix B) details a list of service-level indicators that form part of our overall performance framework. We will report progress against these measures in our Annual Report.

Performance and intervention framework



SECTION 2: Delivering on Priorities

Introduction

On 10 March 2020, the Minister of Health set out DHB priorities for 2020/21. This section details our key programmes to deliver on these priorities. More information on the performance measures required by the Ministry is provided in Section 5.

Effective implementation of activities to meet these priorities and the achievement of milestones requires coordinated input and effort across multiple stakeholders to achieve real health gain for our communities. Overall leadership and accountability for the priority areas in this section generally sits within the Planning, Funding and Outcomes directorate, except where the focus is provider specific. Responsibility for delivery may sit across multiple stakeholders and collaborative priority setting and accountability is critical.

Several of the priority areas below benefit from, or are directly influenced by, the connections we share across the northern region. Many actions make sense to progress regionally just once, in a collaborative and consistent manner, rather than independently by each DHB. These were developed with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups and represent the thinking of clinicians and managers from both our hospital and community settings. Our NRLTHP provides the detail on this longer term regional work, while the Regional Services Plan lays out the actions, milestones and performance indicators for achievement over the coming year.

This is the first year that the region's public health unit (PHU) annual plan is expected to be incorporated into the DHB Annual Plan. The Auckland Regional Public Health Service (ARPHS) is hosted by Auckland DHB, therefore most of the information relating to the following priority areas can be found in the 2020/21 Auckland DHB Annual Plan and referenced in the 2020/21 Waitematā DHB Annual Plan:

- Cross-sectoral collaboration including Health in All Policies
- Drinking water
- Environmental and Border Health
- Communicable Diseases.

Actions to improve equity

Auckland DHB is committed to helping all of our residents achieve equitable health outcomes. Specific activities have been designed to address Te Tiriti responsibilities and to reduce health equity gaps for Māori. We also prioritise Pacific given the historical underservice to this population and the extreme disparities in health outcomes. These activities are identified as 'EOA'.

Government Planning Priorities

Give practical effect to He Korowai Oranga – the Māori Health Strategy

He Korowai Oranga, the Māori Health Strategy sets a vision of pae ora – healthy futures. Priorities include continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe.

Engagement and obligations as a Treaty partner Actions to meet the Treaty of Waitangi obligations, as specified in the NZPHD Act		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We have health equity for Māori and other groups **Government priority outcome**: Support healthier, safer and more connected communities		
DHB activity (all are EOA)	**Milestone**	**Measure**
Northern Iwi-DHB Partnership Board • Collaborate with partner DHBs to support the operation of the Northern Iwi-DHB Partnership Board (Partnership Board) • Embed the Partnership Board in decision making processes across the health system (Auckland, Waitematā and Northland DHBs); Partnership Board Chair to attend DHB Board meetings	Jun 2021 Jun 2021	SS12: Engagement and obligations as a Treaty partner reporting • Dec 2020 • Jun 2021 Host four Northern Iwi-DHB Partnership Board meetings
Māori Led Health Equity Work Plan Develop, in partnership with iwi, a Māori health equity work plan • Support iwi partners to identify their health and wellbeing priorities for the plan • Align the equity plan to wider national and regional health sector priorities • The Partnership Board will have oversight of the delivery of this plan as a key accountability tool for the iwi and DHB relationship • Seek endorsement for the Plan by the Partnership Board • Support and resource first-year activities from this plan in partnership with iwi where applicable	Dec 2020 Dec 2020 Dec 2020 Feb 2021	
Training for Board Members Host training sessions for Auckland and Waitematā DHB Boards, the topics will include (by quarter): • Treaty of Waitangi • Racism and bias • Māori health inequities • Mātauranga Māori	Jun 2021	Monitor the number of Board members who provide evidence of Tiriti training
Support the Partnership Board and the Auckland and Waitematā DHBs' Boards and Executive teams to give effect to their Tiriti obligations	Quarterly reports to Partnership Board	One collaborative research project is operational per annum
Auckland and Waitematā DHBs will maintain their research relationships with MoU partners		

Māori Health Action Plan Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We have health equity for Māori and other groups **Government priority outcome**: Support healthier, safer and more connected communities		
DHB activity (all are EOA)	**Milestone**	**Measure**
Accelerate the spread and delivery of Kaupapa Māori services		
Define and understand our Kaupapa Māori health system, services and partners • Define 'Kaupapa Māori' for endorsement by the Partnership Board • Roll out this definition across Auckland and Waitematā DHBs by socialising this definition with the Boards, executive teams and the Planning, Funding and Outcomes (PFO) Department • Host a forum with kaupapa Māori health providers • Undertake a sustainability review of all current kaupapa Māori health providers across Auckland and Waitematā DHBs and report finding to the Partnership Board • Define a Kaupapa Māori service delivery model within Auckland and Waitematā DHBs	Dec 2020	
Draft the Kaupapa Māori service action plan and submit to the Partnership Board	Jun 2021	
Māori health research • Tino Rangahau, the Māori Health Centre of Research Excellence, will embed kaupapa Māori research methodologies within Māori research practice requirements • Consult with iwi, Māori and MoU partners to understand their priorities that will be reflected in the DHBs' research agenda • Support Māori health researchers to undertake research into the agreed Māori/iwi health priority areas	6-monthly reports to Partnership Board	Number of attendees who respond by survey that they were satisfied with the biannual kaupapa Māori research workshops
Shifting cultural and social norms		
• Provide tikanga-based strategic leadership across Auckland and Waitematā DHBs • Tikanga Māori ethics will be at the forefront of the Māori review process across Auckland and Waitematā DHBs	Quarterly reports to Partnership Board	Number of tikanga-based training sessions scheduled annually 90% of research applications meet the minimum Māori review criteria
Design and implement a report to demonstrate candidate and workforce ethnicity at organisation and directorate levels, to include six Tumu Whakarae targets	Dec 2020	
Undertake learning needs analysis (by profession) for Tiriti o Waitangi training programmes. Implement new programmes as required, underpinned by Nga Pou Akoranga Learning Outcomes Framework	Jun 2021	
Establish Te Tiriti o Waitangi training as a mandatory programme, starting with Executive Leadership and the PFO Department	Jun 2021	
Encourage managers to complete the Management Development Programme Module, Leading for Equity	Jun 2021	80% managers completed module
Develop Leadership expectations for 'leading change for equitable outcomes'	Jun 2021	
Design and implement 'equity' community of practice, ensuring regular meetings	Dec 2020	
Develop an ELT-approved plan to support the roll-out of equity components of a new organisational strategy to include human resource requirements, learning and development options	Jun 2021	
Implement a speaker series to focus on Māori health and institutional racism	Jun 2021	

Māori Health Action Plan Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems		
Reducing health inequities - the burden of disease for Māori		
Equity decision making framework • Through engagement with key stakeholders (Iwi, MoU partners and Māori), develop an equity decision making framework that will support the prioritisation of the DHBs' equity work programme and system change over the next 2 – 5 years • Seek endorsement for the framework by DHB executive, governance and the Northern Iwi-DHB Partnership Board	Jun 2021	
Implement the findings from the Auckland-Waitematā DHB contract equity audit across all Funder contracts and report progress to the iwi-DHB Partnership Board	Dec 2020	
Mātauranga Māori will be a core driver of Māori research activities across Auckland and Waitematā DHBs	Quarterly reports to Partnership Board	Number of mātauranga research projects submitted for funding
Work to establish Te Kahu Aroha o Rongo as the Indigenous Addictions Centre for Auckland and Waitematā DHBs: • Model of care drafted and presented to the Partnership Board • Strategic business case development for an indigenous healing and addictions centre with kaupapa Māori values at the core and a multi-disciplinary model of care • Funding investigation and cost benefit analysis • Economic and financial case and implementation plan, to be developed for capital investment and operating activity, including management structures, processes and resource requirements	Sep 2020 Mar 2021 May 2021 Jun 2021	
Strengthening system settings		
Develop a kaupapa Māori investment framework designed in partnership with the Māori health sector • Co-design a framework for identifying gaps across the system for investment by the Partnership Board/DHB Boards • Use the priorities of the Partnership Board to undertake first-year system reviews	From Mar 2021	
• The Auckland and Waitematā DHBs' Directors/Executive teams will embed tikanga imperatives within Services/Departments • The Auckland and Waitematā DHBs' funding processes will prioritise impact on Māori health as a funding criterion • Annual funding activity report will include an equity analysis	Regular iwi Partnership Board reporting Jun 2021	Two tikanga audits of services per DHB will be carried out on two relevant mainstream health services
• Tino Rangahau, the Māori Health Centre of Research Excellence, will work to form international, national, and regional research enabling collaborative development of research studies that improve Māori and indigenous health	Ongoing	Monitor the number of collaborative research proposals submitted annually
Establish a mental health commissioning group • The Auckland DHB Mental Health Commissioning Board will assess all funding decisions against equity criteria • An equity expert will be a part of the Commissioning Board	Jul 2020	

Improving sustainability

As New Zealand's population has continued to grow and age, with more complex health needs, an enhanced focus on improving sustainability is required. This includes both immediate and medium term supports improvements in system sustainability including significant consideration of models of care and the scope of practice of the workforce. We need to

work collectively with our sector partners to deliver the Government's priorities and outcomes for the health and disability system while managing cost growth.

Improved out year planning processes Financial and workforce actions to improve outyear planning processes		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We live longer in good health **Government priority outcome**: Ensure everyone who is able to, is earning, learning, caring or volunteering		
DHB activity	**Milestone**	**Measure**
Financial The key actions to improve out-year planning processes include:		
• Reviewing and enhancing the DHB's financial planning processes and tools to enable robust analysis of cost, revenue and volumes' trends and drivers for these. This will inform 2021/22 budgets and onwards	Jun 2021	Financial planning processes and system reviews completed and any changes implemented
• Increased focus on long term cashflow management given the deficit situation to ensure the DHB is able to continue to meet its financial obligations both operational and for capital	Dec-20	Cash managed to meet DHB obligations throughout the year
• Improved capital planning, prioritisation and investment processes to develop evidence based long term asset renewals, future asset requirements, financing options and model affordability scenarios	2020/21 and onwards	Long Term financial planning model developed
Workforce • Work with Regional DHB partners on the development of the ISSP HRIS Strategy, which includes defining the Workforce Planning tools and capability needed: - ISSP HRIS strategy completed	Jun 2021	
• Identify and mitigate barriers to region-based workforce planning, including data, recruiting as a region, and improving intra-organisational flow	Ongoing	

Savings plans – in-year gains Actions to meet in-year savings plan objectives		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We live longer in good health **Government priority outcome**: Ensure everyone who is able to, is earning, learning, caring or volunteering		
DHB activity	**Milestone**	**Measure**
The 2020/21 budgeted deficit of $69M includes $30M of savings. Actions to meet the in year savings objectives include: • Savings will be monitored and reported internally on a monthly basis and variances and year end implications identified and explained • Responsibility for savings achievement and overall budgetary control to ensure the bottom-line is achieved will sit with each service directorate where planned savings are to be generated. Overall DHB financial performance will be monitored by senior leadership and at governance to achieve the planned result • On-going identification and planning for new savings initiatives will continue to develop new savings for future years	Jun 2021	Full year planned result achieved
The $30M savings are from the following categories: • Revenue growth - $5M • Cost containment -$15M • Demand growth management and productivity - $10M	Jun 2021	Savings achieved

Savings plans – out year gains Actions to meet out-year savings plan objectives and that support innovative models of care/workforce development		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We have health equity for Māori and other groups **Government priority outcome**: Ensure everyone who is able to, is earning, learning, caring or volunteering		
DHB activity	**Milestone**	**Measure**
Continue to implement savings initiatives identified in the in-year-gains section above, identify new savings and performance improvement initiatives and manage DHB cost growth to at least achieve the planned result or better	Jun 2021	Overall achievement of the planned budget
Manage delivery to planned volumes to minimise IDF and Planned Care revenue impacts	Jun 2021	Minimised adverse IDF and Planned Care revenue wash-ups $30m per annum sustainable and ongoing savings required over the three outyears
Continue to work with the region on service model of care changes to deliver efficiencies and live within available funding	Jun 2022 and out-years	$20m per annum saving required
Full implementation of technical pricing	From July 2021 onwards	
Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability		
• Develop and implement recruitment/development workforce action plans for: - National Cancer Action Plan - Planned Care Improvements - Bowel Screening	 Jun 2021 Jun 2021 Jun 2021	Care navigator clinical nurse specialists (CN CNS) employed to fast track planned care for Māori and Pacific patients • 7 Māori CN CNS • 7 Pacific CN CNS
• Implement regional recommendations related to the: - theatres workforce review - reviews for medical imaging and cardiac workforces	Jun 2021	
As outlined in the Northern Region Long-Term Health Plan's workforce areas, the following will be progressed: • strengthen the partnership approach to improve professional workforce development, focusing on these priority groups: medical imaging, MRI/MIT, MIT, nuclear medicine technicians and cardiac sonographers - set up workforce development-based alliances with health education providers to influence the quality of training and readiness of future workforces - explore options for micro-credentialing and optimising student clinical placements, and other models that fast track workforce readiness reviews for medical imaging and cardiac workforces - identify and progress workforce red flag issues for the region e.g. anaesthetic assistant, MRI MRT and cardiac sonography workforces • support regional MALT/PALT workforce development activity outlined in the Northern Region Long-Term Health Plan and the 2020/21 Regional Services Plan - Strengthen workforce planning to enable delivery of the Northern Region Long-Term Health Plan and the short-term response to the supply and demand challenges as a result of COVID-19 - Plan for and act to secure and prepare our workforces in the post-COVID-19 setting and to support increasing demand across our vulnerable communities	 Ongoing Jun 2021 Jun 2021 Jun 2021 Ongoing Jun 2021 Jun 2021	

Savings plans – out year gains Actions to meet out-year savings plan objectives and that support innovative models of care/workforce development		
Nursing – equity underpins practice (EOAs) • Audit the Māori nurse uptake of Auckland DHB's Professional Development Recognition Programme (PDRP)	Jun 2021	100% of Auckland DHB Māori nurses audited will have a PDRP
• Māori nursing leadership representation in all Directorates with a monthly hui planned • All new Māori graduates identified and supported by past Māori graduates	Jun 2021 Feb 2021	10 Directorates represented by Māori leadership 100% of Māori graduates remain in employment for two years
Nursing – scope of practice and models of care • Ensure new graduate enrolled nurses are employed as part of the DHB's model of care	Jun 2021	Increase clinical placements for enrolled nurse students from four to eight per semester
• Improve access to clinical placements and employment opportunity through the nursing scholarship programmes, particularly for Māori and Pacific nursing students - Full disbursement of scholarship funds for clinical placements	Aug 2020	Four in total: Pacific and Māori enrolled nurses employed on graduation in 2020, 2 in 2021 3 Māori scholarship recipients employed as RN NETP at Auckland DHB 2021
• Improve access to prescribing training for nurses - Improve access by prioritising post-graduate health workforce funds for this training - Work with metro-Auckland DHBs/PHOs to utilise Auckland DHB's allocated placements into the community prescribing training programme	Jun 2021 Jun 2021	16 registered nurses complete prescribing practicum 30 placements into community prescribing training programme
Refer to the Maternity and Midwifery workforce and Mental Health and Addiction System Transformation sections in Section 2 for other workforce activities as well as the Workforce section in Section 4: Stewardship		

Working with sector partners to support sustainable system improvements Actions that demonstrate collaboration with sector partners to support sustainable system improvements		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Implement the actions specified under Priority Area 5 'Cross-sector action' of the Māori Health Action plan, once finalised		
Continue to develop local initiatives that bring together iwi, hapū, DHBs and other social agencies: **Noho Āhuru – Healthy homes** Work with providers to increase the number of pregnant women referred to Noho Āhura in their first trimester, and complete all interventions so newborn babies are discharged into warm, dry healthy homes **Healthy babies healthy futures (HBHF)** Support providers to partner with eight external community organisations (including Kohanga Reo, Pacific and South Asian church groups) to deliver HBHF services (health promotion for families and pregnant women) **Healthy Auckland Together** Work with partners to implement the Healthy Active Learning initiative to encourage all schools and early learning settings (ELS) to implement healthy food and drink policies, with a focus on early learning settings and schools with high Māori and Pacific populations • Complete data collection from ELS and schools through use of the prioritisation tool to determine what schools currently have a policy in place and at what stage it is	Mar 2021 Jun 2021 Jul 2020	Establish the baseline proportion of eligible Māori and Pacific women referred to Noho Āhura – Healthy Homes in the first trimester of pregnancy Enrol 900 people onto the TextMATCH programme by Jun 2021, with a minimum of 225 enrolments for Māori, Pacific and South Asian communities 3% reduction (from Dec 2019 baseline) in acute bed days for Māori and Pacific populations
Implement the targeted health promotion and prevention initiatives specified in the SLM Improvement Plan (once finalised) aimed to reduce acute bed days for Māori and Pacific. Better integration between community, primary and secondary care will maximise the use of available health resources	Jun 2021	

Improving child wellbeing

We are actively working to improve the health and wellbeing of infants, children, young people and their whānau, primarily through prevention and early intervention services, with a particular focus on improving equity of outcomes.

Maternity and Midwifery workforce – hospital and LMC Actions to train, support, recruit and retain our maternity and midwifery workforce		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Extend the Te Manawa o Hine midwifery continuity of care team for Māori women • Appoint two Māori Midwife Specialist roles providing specialist coordinated midwifery care to women with highly complex medical and social needs (EOA) • Employ or contract at least one additional Pacific midwife to grow the Pacific midwifery workforce and provide continuity of care for Pacific women (EOA)	Sep 2020 Jun 2021	Increase Māori midwifery workforce by 5% (from Jun 2019 baseline) by Dec 2020
Review Kaiawhina roles to support Te Manawa o Hine to provide education, public health messages, cultural advice, to support	Dec 2020	

Maternity and Midwifery workforce – hospital and LMC Actions to train, support, recruit and retain our maternity and midwifery workforce		
midwives and wāhine Māori (EOA) • Complete a plan, including position description and application/business case for the roles		
Review RN/EN role in inpatient units to offer discharge parenting and public health education to women • Complete a plan, pilot the plan, and develop a business case for ongoing service for this new role	Dec 2020	
Develop and employ Māori and Pacific cultural and clinical practice coaches to support midwifery students and graduates within the Auckland DHB workforce (EOA) • Undertake planning for these positions as stand-alone or integrated; develop position descriptions and advertise for cultural and clinical practice coaches	Dec 2020	
Continue to plan and prepare for seasonal changes in service demands with various strategies, e.g. increasing community midwifery and lactation services, recruitment of additional midwives	Ongoing	

Maternity and early years Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Make New Zealand the best place in the world to be a child		
DHB activity	**Milestone**	**Measure**
Further increase access and improve pathways to ensure more women have planned pregnancies with better access to long-acting reversible contraceptive choices	Jun 2021	Establish baseline 90% of Māori women surveyed report that their general practice helped them engage with a LMC midwife, or other appropriate maternity provider 85% of Māori women and 85% of Pacific women book with an LMC in the first trimester of pregnancy 75% of Māori newborns enrolled with GP by 3 months of age 75% of Māori infants have their 6-week WCTO check on time Trial four alternative safe sleep space devices
Develop and consult on postnatal support options for women who elect to be discharged early from maternity facilities, with a focus on culturally appropriate support for Māori and Pacific women (EOA)	Dec 2020	
Work with primary care to actively engage all pregnant women seen in primary care with a midwife	Sep 2020	
Using newly available data from NCHIP, undertake a gap analysis to review equity in the 4-6 week infant handover and engagement processes, and agree follow on actions with Maternity, WCTO providers and General Practice (EOA)	Sep 2020	
Scope the development of culturally appropriate 'health weight/healthy conversations in pregnancy' teaching package for health professionals in collaboration with maternity partners	Jun 2021	
Develop a Community Champions movement to support and promote SUDI prevention (EOA)	Dec 2020	
Launch safe sleep and SUDI education campaign on social media (EOA)	Dec 2020	
Trial alternative safe sleep space devices with Pacific women and gain feedback on acceptability (EOA). Evaluate feedback and incorporate into safe sleep device options offered in DHB programme to ensure a wide range of safe sleep options are available to whānau and fono	Mar 2021	
Undertake a review to better understand the access barriers to pregnancy ultrasound for hapu Māori and Pacific women	Dec 2020	
Pregnancy and parenting education: • Complete review of pregnancy and parenting education • Develop responses to feedback, particularly from Māori and Pacific women • Review findings reflected in contractual arrangements for 1 Jul 2022	Dec 2020 Mar 2021 Jun 2021	

Immunisation

Actions to improve and maintain high childhood immunisation rates

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Make New Zealand the best place in the world to be a child

DHB activity	Milestone	Measure
Work with Māori partners and the National Child Health Information Platform (NCHIP) to develop an approach to monitor individual level immunisation status of quintile 5 Māori infants (EOA)	Jun 2021	95% of 8-month-old infants and children aged 2 and 5 years (including Māori) are fully immunised (CW08, CW05 measures) 50% of hapū Māori and Pacific women receive the pertussis vaccine (baseline Māori = 23%, Pacific 24%)
Work with the Ministries of Social Development and Education to safely share contact information for quintile 5 children who are overdue immunisations and not responding to contact attempts	Dec 2020	
Work with Maternity, Well Child Tamariki Ora providers, Primary Healthcare and Māori Health Gains team to implement a continuous quality improvement project to increase antenatal immunisation	Jun 2021	
To address access issues caused by COVID-19 and with a focus on Māori and Pacific infants: • Share information with PHO, WCTO and OIS providers in support of catching up on all scheduled immunisations • Facilitate WCTO providing immunisation services	 Ongoing Jun 2021	

School-Based Health Services (SBHS)

Actions to improve the health of our youth population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Implement the following quality improvement actions in line with the Youth Healthcare in Secondary Schools framework: • Introduce YouthChat as part of Year 9 HEEADSSS assessment and evaluate the effectiveness of the enhanced assessment particularly on improving health outcomes for Māori and Pacific students (EOA) • Establish enhanced SBHS in all decile 5 schools • Ensure each ESBHS school has a healthy food and drink policy in place (EOA) • Scope and pilot a standardised youth appropriate education package on vaping for SBHS schools (EOA) • Design and implement a catch-up vaccination programme for students who are not fully immunised with a particular focus on Māori and Pacific students (EOA)	 Jan 2021 Jan 2021 Dec 2020 Jan 2021 Jan 2021	 80% of decile 1-5 schools have a healthy food and drink policy 95% of consented Year 9 students in decile 1-5 schools are fully immunised
Use the Results-Based Accountability Framework to support quality improvements through the Youth Health Clinical Alliance	Ongoing	
Continue to provide regular reports to MoH on the: • Service delivery of SBHS in decile 1-4 secondary schools, teen parent units and alternative education facilities • Actions of the SLAT to improve the health of our youth	 Q2,Q4 Quarterly	
To catch up on psychosocial/wellbeing assessments that have been delayed due to COVID-19 restrictions: • Support nurses with additional resources (Roaming Nurse and YouthChat) • Prioritise HEEADSSS assessments for Māori and Pacific young people	 Jan 2021 Jan 2021	
Refer to the Healthy Food and Drink section for further activities in schools		

Family violence and sexual violence Actions to reduce family violence and sexual violence in our communities		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Introduce a standardised programme to inform young people about consent and relationship issues, into the SBHS programme • Programme agreed and joint nurse and guidance counsellor training completed • Feedback from young people demonstrates improved understanding of consent	Sep 2020 Jun 2021	
Audit Family Violence screening undertaken under Noho Āhuru – Healthy Housing: • establish quality improvement plan, ensuring appropriate pathways and supports are available to victims and perpetrators (EOA) • develop and baseline a measure for routine enquiry and disclosure rates and establish a target for 2021/22	Dec 2020 Dec 2020	

Improving mental wellbeing

Auckland DHB will embed a focus on wellbeing and equity at all points of the system, with increased focus on mental health promotion, prevention, identification and early intervention. We will strengthen existing services to ensure that mental health services are cost effective, results focused and have regard to the service impacts on people who experience mental illness. Our range of services will be of high quality, safe, evidence based and provided in the least restrictive environment.

Mental Health and Addiction System Transformation Working in collaboration with all stakeholders to transform mental health and addiction services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Placing people at the centre of all service planning, implementation and monitoring programmes		
As part of our Māori CTO programme of work, pilot the use of flexi funding to provide Māori access to free medication to establish whether this increases discharge (EOA) Use the Health of the Nation Outcomes Scale to measure positive and negative changes in health, wellbeing and circumstances	Pilot completed by Jun 2021 Jun 2021	Determine whether the pilot reduces the number of Māori on CTOs (baseline of 80 in CY 2019)
Develop an annual strategic plan for the involvement of lived experience to improve outcomes for consumers that includes a monthly review schedule	Oct 2020	
Develop a consistent methodology to collect, collate and analyse feedback from service users and their families to inform service development • Socialise methodology • Utilise methodology across mental health services	Oct 2020 Apr 2021 Jun 2021	
Develop staff training programmes to support equity in recruitment (EOA) and initiate quarterly	Dec 2020	
Embedding a wellbeing and equity focus		
Develop Equally Well assessment, protocols and intervention logics	Apr 2021	

Mental Health and Addiction System Transformation Working in collaboration with all stakeholders to transform mental health and addiction services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes		
• Tools and protocols in place and being utilised	Jun 2021	
Supporting Parents Healthy Children (COPMIA) • Consolidate family inclusive practice through increased screening for parenting status • Increase the pool of staff trained in Single Session Family Consultation	Dec 2020 Dec 2020	50% of screening forms completed 100% increase of staff trained in the model (vs. 2014 baseline)
Via the Tuhono partnership working group, develop a green prescription pathway for people supported by Mental Health and Addictions (MHA) NGO providers	Jun 2021	50 people access service via the green prescription pathway
Develop a service model and therapeutic programme for Te Whare Hinatore (previously named Manaaki Wāhine), in partnership with MHUD, ACC, MSD and Auckland City Mission	Jun 2021	30 women successfully complete the programme
Evaluate Haven Recovery café to improve engagement with Māori, Pacific and Rainbow communities	Oct 2020	
Establish a commissioning board, which will collaborate with key partners to help drive transformation in line with He Ara Oranga	Oct 2020	
Increasing access and choice of sustainable, quality, integrated services across the continuum		
Develop an acute options project to review literature, scope a range of acute options and develop corresponding business cases	Dec 2020	
Increase delivery of a wider range of MHA community-based options in line with the Ministry's investment in primary MHA, including expansion of HIP, Health Coach and Awhi Ora positions • Contracts signed with NGO and PHO partners • Initiate open procurement processes for expansion of delivery of all three models	 Sep 2020 Mar 2020	
Development of a metro-Auckland governance group overseeing the primary mental health investment from Ministry into access and choice. To include partnership with NGO, PHO, DHB, Māori, Pacific, young people and those with lived experience • Terms of reference endorsed by governance group • Develop reporting mechanisms including setting of baseline data for primary mental health investment	 Jul 2020 Oct 2020	
Suicide prevention		
Develop an action plan to include activities to promote wellbeing, respond to suicide distress, respond to suicidal behaviour and support people after a suicide. The plan is aligned with Every Life Matters and endorsed by the Suicide Prevention and Postvention Governance Group (SPPGG) • Develop and implement routine data monitoring and reporting instruments to capture key trends in suicide mortality	Oct 2020 Nov 2020	
In partnership with SPPGG, develop and implement Māori-specific suicide prevention actions (EOA) • Submit plan to the Suicide Prevention Office	 Oct 2020	
Continue to develop and implement the Zero Suicide Framework for the Auckland DHB catchment • Review and adapt the framework for cultural fit and health equity (EOA)	 Dec 2020	
Workforce		
Procure new positions to expand primary mental health models, including specific focus and reference to the value of lived experience, peers and whānau	Mar2021	
The service model of Te Whare Hinatore (previously named	Dec 2020	100% of recovery café and 15% of Te

Mental Health and Addiction System Transformation Working in collaboration with all stakeholders to transform mental health and addiction services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes		
Manaaki Wāhine) and recovery cafe, will privilege lived experience, peers and whānau in employment and recruitment strategy and future service development		Whare Hinatore workforce are peers
Develop strategies to support workforce retention, recruitment, training and wellbeing • Develop and implement the nursing strategy priorities • Develop and socialise the Allied Health action plan; initiate priorities • Develop and socialise the medical workforce action plan; confirm and implement priority actions	 Aug 2020 Sep 2020 Dec 2020	
Commitment to demonstrating quality services and positive outcomes		
Further explore challenges to meeting access and waiting times in our service • Develop a greater knowledge and understanding of challenges associated with access and waiting times • Develop and implement action plan to address challenges	 Dec 2020 Jun 2021	
Further explore challenges to timely completion of transition discharge and care plans • Develop a greater knowledge and understanding of challenges associated with access and waiting times • Develop and implement action plan to address challenges	 Dec 2020 Jun 2021	
Please refer to our service provider Waitematā DHB's 2020/21 annual plan for forensics activities		

Mental health and addictions improvement activities Actions to improve population mental health and addiction, particularly in our priority populations		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Zero seclusion: work towards eliminating seclusion • Improve availability and access to activities in the acute adult inpatient unit • Develop guidelines to managing acute intoxication in TWT	 Aug 2020 Dec 2020	80% of staff complete unconscious bias training by April 2021
Connecting Care: planning for improvement activities to ensure a safe and connected experience for service users transitioning from the IPU to two community sites to improve transition/ discharge using the PDSA cycle (one site is Māori Mental Health Services to focus on equity; EOA) Test, review, modify and implement new care planning	Dec 2020	
Involve service users and whānau in reviewing learnings from serious adverse events • Develop a survey to collect feedback from service users and whānau • Agree and implement processes across all service groups	 Aug 2020 Sep 2020	

Addiction Actions to support an independent and high quality of life in people with addiction issues, particularly priority groups		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Following submission of the Northern Regional Alliance model of care AOD review, which will be cognisant of the AOD national model of care, implement agreed recommendations with consideration of baseline funding available	Dec 2020	
Continue to engage with the regional AOD collaborative, including DHB funder and provider attendance at the northern region collaborative quarterly meetings	Jun 2021	
Please refer to our service provider Waitematā DHB's 2020/21 annual plan for additional addiction activities		

Maternal mental health services Actions to improve equity of access and outcomes, particularly for Māori and Pacific women		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Based on research to improve equity of access for women to secondary maternal mental health services, endorse recommendations and develop an implementation plan for (EOA): • Pacific women • Asian women	 Dec 2020 Jun 2021	
Support capability development in primary care nurses and midwifery	Jun 2021	At least 3 professional development sessions are delivered to midwifery colleagues by the Specialist Maternal Mental Health team (GP training provided on request) One module delivered to each cohort of the Primary Care Nurse Credentialing Programme

Improving wellbeing through prevention

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and health lives, working with other agencies to address key determinants of health, and to identify and treat health concerns early in the life course and in the life of progress of the disease.

Environmental sustainability Actions to positively mitigate or adapt to the effects of climate change and their impacts on health		
Government themes: Improving the wellbeing of New Zealanders and their families; build a productive, sustainable and inclusive economy **System outcome:** We have improved quality of life **Government priority outcome:** Transition to a clean, green and carbon neural New Zealand		
DHB activity	**Milestone**	**Measure**
Develop a Sustainable Transport Strategy to provide alternative sustainable travel options for staff, patients and visitors • Strategy approved by Board	 Nov 2020	30-50% of general pantry office supplies to be green-based

Environmental sustainability

Actions to positively mitigate or adapt to the effects of climate change and their impacts on health

Continue construction waste pilot programme and report waste diverted from landfill to provide baseline data on recyclable construction waste	TBC	
Change general pantry office supplies to green-based and sustainable options	Dec 2020	

Antimicrobial Resistance (AMR)

Actions to improve equity in outcomes and patient experience

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Aged Residential Care (ARC) Continue to use the ARC forum and cluster groups to ensure facilities are informed of front-line infection prevention and control practices and the CPE Guidelines; monitor corrective actions from ARC audits for the Infection Prevention and Control Standard	Ongoing	3 forums
Primary care • Institute a primary care clinical governance committee • Develop an education plan, endorsed by the Metropolitan Auckland clinical Governance Forum and the ALT, to support improved antimicrobial prescribing, with a primary focus on Māori in primary care (EOA) but also with a focus on other high need populations • Clinical governance committee will continue to report to the Metro-Auckland Governance Forum who report to ALT	Dec 2020 Jun 2021 Ongoing	
Hospital • Hold a workshop for ARC providers to support professional development activities on AMR within the sector • Participate in the HQSC Point Prevalence Survey to determine the burden of healthcare-associated infections (HAI) in our adult patients, by ethnicity (EOA) • Review our MRO screening policy in response to findings from the audit of policy adherence and develop an IPC Committee-approved recommendation implementation plan • Evaluate the implementation of the process for reviewing antibiotic and allergy history to identify and remove incorrect penicillin allergy alerts from patient records: - audit 100 patients - complete review of tools used to support process	Oct 2020 Dec 2020 Jun 2021 Dec 2020 Dec 2020 Jun 2021	% of adult patients with an HAI by ethnicity

Drinking water

Actions to support our Public Health Unit to deliver drinking water activities

Government themes: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
• Within the funding provided, the Auckland Regional Public Health Service (ARPHS) will work to deliver the activities		% of medium and large network water supplies compliant with the

Drinking water Actions to support our Public Health Unit to deliver drinking water activities		
contained in the Environmental and Border Health exemplar (drinking water) across the region (Auckland, Waitematā and Counties Manukau DHBs) • ARPHS reports against the performance measures contained in the Vital Few Report (drinking water) and the measures contained in the Environmental Health exemplar (drinking water)	As required	Health Act 1956 Target: 100% Baseline: 100% (2017/18[1])
ARPHS promotes compliance with the drinking water requirements of the Health Act 1956	Jun 2021	% of networked water supplies receiving at least one compliance assessment per annum with findings confirmed in writing Target: 100% Baseline: 100% (2018/19)
As part of the Drinking Water Technical Advice Services, ARPHS provides: • technical and public health support to all marae-based registered networked drinking water supplies serving 25 to 5000 people (EOA) • regular narrative reports on work with maraes/papakainga	As required	

Environmental and Border Health Actions to ensure compliance with environmental and border health legislation		
Government themes: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
• Within the funding provided, the Auckland Regional Public Health Service (ARPHS) will work to deliver the activities contained in the Environmental and Border Health exemplar across the region (Auckland, Waitematā and Counties Manukau DHBs) • ARPHS reports against the performance measures contained in the Vital Few Report and the measures contained in the Environmental Health exemplar. • In border health, ARPHS provides a timely response to interceptions of medical vectors, such as exotic mosquitoes of human health significance	As required	% of responses initiated within 2 hours of notification Target: 100% Baseline: 100% (2018/19)
ARPHS responds promptly to high-risk enterics due to the risk of disease spread	As required	% of high risk enteric disease cases for which the time of initial contact occurred during the same day of notification (Shigella and New Zealand acquired typhoid and paratyphoid) Target: 95% Baseline: 89% (2018/19)
When issuing permissions for the use of Vertebrate Toxic Agents (VTAs) for pest control, ARPHS ensures that consultation with Māori (iwi/hapū/whānau) has taken place and that the evidence provided by the applicant supports this consultation (EOA)	As required	% of approved applications with supporting evidence of consultation with Māori (iwi/hapū/whānau) Target: 100% Baseline: 100% (2018/19)

[1] Data source: Drinking Water Annual Survey (previous year's results). Latest baseline year available: 2017/18.

Healthy food and drink

Actions to create supportive environments for healthy eating and healthy weight

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Continue to implement the National Healthy Food and Drink Policy for staff and visitors, targeting priority groups, e.g. Māori and Pacific (EOA)	Dec 2020	Compliance with the national policy (≥55% 'green' and <45% 'amber' food options) Number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts – report in Q2 and Q4
Ensure the pre-developed clause requiring all providers to develop a Healthy Food and Drink Policy in all locally funded contracts is being implemented by providers	Jun 2021	
In collaboration with ARPHS and the Healthy Active Learning initiative, report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water and milk only and healthy food policies	Dec 2020	

Smokefree 2025

Actions to advance progress towards the Smokefree 2025 goal

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Fund the local stop smoking service to provide an incentive programme to support Māori and Pacific hapū wāhine and their whānau to stop smoking and encourage referrals from health professionals to this programme (EOA)	Ongoing in 2020/21	110 hapū wāhine and 36 whānau are referred to the local stop-smoking service (measured by ethnicity: Māori, Pacific and other)
ARPHS undertakes compliance activities as per the Smoke-free Environments Act 1990 and reports against the performance measures contained in the Vital Few Report.	Jun 2021	
ARPHS leads and supports collaborative actions with key stakeholders to make progress towards Smokefree 2025 and reports on outcomes	Jun 2021	
Controlled Purchase Operations (CPO) designed to monitor and enforce provisions related to the Smokefree Environments Act 2003 to focus on high deprivation areas (NZDep 7-10)	Jun 2021	% of tobacco retailers visited during CPOs in NZDep areas 7-10 Target: 70% Baseline: 77.1% (2018/19)

Note: Auckland DHB will support Auckland Regional Public Health Service (ARPHS) in their work focused on changing social attitudes towards tobacco consumption and exposure in Tāmaki Makaurau, smokefree open areas and partnership-based compliance activity (under the Smokefree Environments Act 2003)

Breast screening

Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific

Government theme: Improving the well-being of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Work with breast screening providers to develop a proposal to pilot and evaluate an incentive programme to engage low income Māori and Pacific women to attend their first breast screen (EOA)	Pilot commenced by Dec 2020	Māori coverage to increase by 2% Pacific coverage to increase by 2% (from Dec 2019 baseline)
Analyse the outcomes data from the Find 500 Māori Women campaign and review the results. Work with the project team including the providers to identify the limitations and strengths of the approach:		

Breast screening Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific		
• Analysis complete • Recommendations shared	Dec 2020 Dec 2020	

Cervical screening Provide equitable access to screening to reduce mortality and morbidity, particularly in Māori, Pacific and Asian women		
Government theme: Improving the well-being of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Pilot and evaluate an incentive scheme for low income Māori and Pacific women who are not or under-screened to access a free smear, including through Family Planning, on the marae and in community settings beyond general practice (EOA)	Dec 2020	Māori coverage to increase by 2% Pacific coverage to increase by 2% (from Dec 2019 baseline)
Trial a home-delivered screening service supported by a Kaiawhina in one geographic area	Jun 2021	

Reducing alcohol related harm Actions to support our Public Health Unit to advance activities relating to reducing alcohol related harm, undertake enforcement of the Sale and Supply of Alcohol Act 2012, and achieve equitable outcomes for Māori ,ensuring programme delivery is underpinned by the Treaty of Waitangi and its principles for Pae Ora – healthy futures for Māori.		
Government themes: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
ARPHS undertakes compliance activities as per the Sale and Supply of Alcohol Act 2012 and reports against the performance measures contained in the Vital Few Report ARPHS inquiries into on-, off-, club and special licence applications in line with regulatory plan ARPHS provides reports to the District Licensing Committee (DLC) where there are matters in opposition related to liquor licence applications.	As required	Monitor the number of license applications and renewals (on, off club and special) received and processed. Baseline: 2018/19: 4,153. % reports (for premises where matters in opposition were identified) provided to the licensing committee within 15 days. Target 100% Baseline: 2018/19: 100%
ARPHS to re-design its processes to give greater consideration and stronger voice to Māori needs when assessing liquor licence applications and reports on outcomes (EOA)	Jun 2021	% of new bottle shop license applications consulted with Ngāti Whātua and Tainui (Te Runanga O Ngāti Whātua and Raukura Hauora O Tainui) Target 100% Baseline year: 2020/21
Following Board endorsement, ensure ongoing implementation of the DHB's Position Statement: Reducing Harms from Hazardous Alcohol Use in our communities: • work with people, whānau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm	Ongoing	
Refer to the 2020/21 Metro-Auckland SLM Improvement Plan – alcohol harm reduction section for further activities and measures		

Sexual health

Actions to advance sexual health services and sexual health promotion work

Government themes: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Complete a Metro-Auckland communications plan alongside NGOs to maximise the impact of multiple organisations' communications, this will be co-designed with Māori and Pacific organisations	Oct 2020	
Control the syphilis outbreaks in Metro Auckland • Strengthen contract tracing • Start syphilis point-of-care (PoC) testing in outreach clinics to improve access • Implement proactive testing aimed at MSM[2], Māori and Pacific, as the most at-risk groups (EOA)	 Ongoing Dec 2020 Mar 2021	
Develop metrics for each service that help us understand our health outcome gaps particularly for our Māori and Pacific patients	Jun 2021	

Communicable diseases

Actions to advance communicable diseases control work

Government themes: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable diseases • public health management of cases of communicable diseases and their contacts • enquiries from medical practitioners, the public and others about suspected communicable diseases of public health concern	Ongoing	Monitor the number of disease notifications received Baseline: 6,957 (2018/19)
• Conduct surveillance in which data is systematically collected, analysed, interpreted and acted upon for the purpose of preventing, identifying and responding to communicable disease issues • Provide a brief summary of surveillance activities	As required	
ARPHS receives tuberculosis (TB) disease case notifications and oversees case and contacts management in partnership with relevant clinical services	As required	% of smear positive pulmonary TB cases contacted by the Public Health Nurse within three days of clinical notification Target: 90% Baseline: 83% (2018/19)
Contact tracing protocols ensure proactive engagement with Māori and Pacific population groups – report on outcomes (EOA)	Jun 2021	

[2] Male sex with male

Cross-sectoral collaboration including Health in All Policies Actions to continue the integration between health and social services, with a focus on influencing healthy public policy towards achieving equity		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
ARPHS works in partnership with other cross- sectoral organisations across the Auckland region to support Health in All Policies in order to achieve equitable health outcomes (EOA). ARPHS: • leads the Healthy Auckland Together (HAT)[3] coalition • leads the Auckland Intersectoral Public Health Group (AIPHG)[4] • participates in the Auckland Social Sector Leaders and the Auckland Social Sector Advisors groups (ASSLG and ASSAG respectively)[5] • reports on the outcomes of collaborative work	Ongoing Six monthly	
ARPHS leads public health-related stakeholder engagement with Auckland Council and Council Controlled Organisations to share knowledge and expertise on public health topics and to promote Health in All policies • Analyse and disseminate public health data to support local government planning • Support Auckland local boards' health and wellbeing action plans • Support Auckland Transport planning and advocacy work • Summary of pilot Local Board Wellbeing Plan development (Puketapapa)	 Jun 2021 Ongoing Ongoing Six monthly	
ARPHS contributes to relevant regional and national policy development processes on wider social and economic determinants of health	As required	Monitor the number of submissions made by type

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

New Zealanders are living longer, but also spending more time in poor health. This means we can expect strong demand for health services in the community, our hospitals, and other care settings. Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

Delivery of Whānau Ora Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity (all are EOA)	**Milestone**	**Measure**
Māori health • The Waitematā and Auckland DHBs will support the	Regular Partnership	Monitor the number of collaborative research proposals submitted

[3] Stakeholders: 25 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups
[4] Stakeholders: DHBs Planning and Funding representatives, Northern Regional Alliance and the Ministry of Health
[5] Forum for senior representatives of government agencies across different sectors

Delivery of Whānau Ora Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity		
development of whānau centred research through collaborative funding activities	Board reporting	annually
Implement phase 3 of the Māori health integrated contracting project: • In partnership with kaupapa Māori providers, support the re-orientation of their services to focus on whānau-centred models of care that align to the needs of their population • Provide long-term integrated contracts for kaupapa Māori health providers	 Jun 2021 Jun 2021	
Pacific health		
Develop a Pacific stakeholder engagement framework/plan that: • identifies opportunities to work collaboratively with Pasifika Futures and other stakeholders to progress the Pacific Health Pipeline programme of work • ensures Pacific stakeholder engagement activities are integrated and undertaken in a co-ordinated manner to improve the effectiveness of our DHBs engagement efforts	Sep 2020	
Agree and implement annual joint work programme with Pasifika Futures	Sep 2020	
Develop a Pacific Insight Framework (PIF) to gain insight into our Pacific cohorts' behaviour, and use these insights to guide investment in whānau-centred approaches and activity that improves service delivery for our Pacific cohorts and communities	Jun 2021	
Explore commissioning approaches to support the integration of services and the delivery of whānau-centred approaches to advance and achieve Pacific health equity	Sep 2020	

Pacific Health Action Plan Actions that demonstrate commitment to supporting delivery of the Pacific Health Action Plan		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We improve Pacific health outcomes **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
We commit to support the delivery of the new Pacific health plan - Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan. We will do this by ensuring alignment of our planned activities, including our Pacific Health Pipeline programme	Jun 2021	
We will update our Auckland-Waitematā DHBs' joint Pacific Health Action Plan to align with the key priority areas of the new Pacific health plan - Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan	Jun 2021	

Care Capacity Demand Management (CCDM) Actions to support the implementation of CCDM for nursing and midwifery by June 2021		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Undertake CCDM FTE calculations into nursing, midwifery and mental health areas by providing FTE calculation workshops • Complete 54 FTE calculations where complete and reliable TrendCare data is available	Jun 2021	

Care Capacity Demand Management (CCDM) Actions to support the implementation of CCDM for nursing and midwifery by June 2021		
Implement VRM into Mental Health Services by establishing a working group, TOR and work plan • Report progress to CCDM Council monthly	Dec 2020	
Ensure all CCDM work plans for each programme are focused on achieving equity for Māori and Pacific people (EOA)	Ongoing	

Disability Action Plan Actions that demonstrate commitment to developing a Disability Action Plan		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
The three Metro Auckland DHBs (Auckland, Waitematā and Counties Manukau) developed a joint Metro-Auckland New Zealand Disability Strategy Implementation Plan for 2016-2026. The Plan focuses on five outcomes of the New Zealand Disability Strategy: Health and Wellbeing, Employment, Choice and Control, Accessibility, and Attitude		
Review the Metro Auckland plan and update accordingly, with a specific focus on the needs of disabled Māori and Pacific people (EOA), as per the current plan's commitment to review the plan in 2020	Dec 2020	
Implement annual accessibility action plan linked to Auckland DHB's Accessibility Tick membership and accreditation	Jun 2021	
Regular meetings of the Accessibility Steering Committee who guide and provide governance to ensure our obligations and actions, both under the Tick and in a broader context, are implemented	Quarterly	4 x meetings per year

Disability Actions to improve access and health outcomes for people with a disability		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Continue to provide online disability training module for staff	Ongoing	35% of staff complete module
Continue to work to the Accessibility Tick framework and raise awareness of disability	Ongoing	
Continue to deliver Disability Confident workshops to recruitment and hiring managers	Ongoing	
Continue to make resources to support employees with a disability available on the DHB intranet	Ongoing	
Continue to update our careers website and recruitment processes to ensure a welcoming and supportive experience for applicants with a disability or access need	Ongoing	
Actively work with supported employment agencies to help facilitate applications from people with a disability or access need	Ongoing	
Ensure that key health information for the public and public health alerts and warnings are accessible by people with a disability (EOA), by: • reviewing internal and external communications for accessibility as part of our ongoing commitment to the Accessibility Tick work programme • work with MoH and the Health Promotion Agency to review content against Government standards for accessibility	Jun 2021	Number of key public health information messages, public health alerts and warnings issued each year and the number of these translated into New Zealand Sign Language, by Q4 2020/21

Planned Care

Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Ensure everyone who is able to is learning, caring or volunteering

DHB activity	Milestone	Measure
The actions below support each of the five Planned Care strategic priorities. Additional actions will be developed as part of the Auckland DHB three-year plan for Planned Care (to be developed by April 2021). The development and implementation of our three-year plan will involve our consumer council and other key stakeholders. Please refer to the Cancer priority section for additional cancer-related activities	Ongoing	Coronary angiography 95% target CT 95% target Acute readmissions 0-28 days <11.6% target (Sep 2019 baseline)
Equity. Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed		
• Improve heart failure disease outcomes for Māori by implementing cultural support for Māori to improve access to Heart Failure services and increase attendance rates (EOA) thereby reducing known variation in current access rates • Implement routine measurement by ethnicity and monthly reporting of waiting time to planned care services from referral to treatment for Māori and Pacific patients in two clinical specialties to enable targeting of additional navigation services to reduce inequities in waiting times	Jun 2021	Reduce non-attendance rates for Māori from 19% to 15% (from 2018/19 baseline) Set baseline and monitor, aiming to reduce, variation in waiting times by ethnicity
Access. Balance national consistency and the local context		
Implement transfer of hospital-based contraceptive clinics to community-based clinics; clinics operational in Glen Innes and Grey Lynn, improving local access to these services	Mar 2021	
Quality. Support consumers to navigate their health journeys		
Implement alternative approaches to managing outpatient follow-ups to reduce the need for unnecessary in-person, on-site appointments, such as virtual appointments, telehealth, patient-directed follow-ups, increase discharging to GPs, and use of the eConsult function within eReferrals and Auckland Regional Health Pathways to support patient management in primary care	Mar 2021	Set baseline and monitor, aiming to reduce overall face-to-face follow-ups
Timeliness. Optimise sector capacity and capability		
Move away from the current service contract approach in MRI Services to a strategic partnership model, where MRI capacity across the catchment is utilised to reduce the need for increase investment in DHB capacity	Jun 2021	MRI 95% target
Experience. Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future		
Improve use and utilisation of theatre capacity at the elective Greenlane Surgical Unit (GSU), including elective activity in a range of specialties, e.g. ophthalmology and urology to reduce demand and likelihood of cancellation due to competing priorities on Auckland Hospital theatre capacity	Jun 2021	Deliver TBC Planned Care Interventions ESPI 1 100% ESPI 2 0% ESPI 3 0% ESPI 5 0% ESPI 8 100% No ophthalmology patients wait ≥50% longer than the intended time for their appointment Achieve ≥75% utilisation of GSU theatre capacity

Acute demand

Actions to improve the management of patient flow and data in the Emergency Department

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Acute data capturing		
We expect to complete SNOMED implementation during 2019/20. In 2020/21, we plan to: • Form project with plan to incorporate changes in the Concerto ED admission and discharge form - Procedure codes - Discharge codes • Progress IT work to ensure data can be extracted and provided to Ministry	 Sep 2020 Dec 2020 Jun 2021	
Acute demand		SS10 measure
Continuing from a 2019/20 trial to segment patients into different areas for care by dedicated medical and nursing teams, implement team-based care in ED to better manage acute demand • Introduce new model of care	Jun 2021 Sep 2020	
Explore and remove barriers to enable direct admission for Starship General Paediatric patients	Jun 2021	
Reduce admissions by revising the Starship UTI guidelines criteria for admission	Jun 2021	
Implement criteria-led discharge in Starship Surgical Services to facilitate discharges from the ward and improve patient flow	Dec 2020	
Implement a bronchiolitis pathway to increase community nursing referrals and follow up to decrease patient admission	Jun 2021	
Equity		
With Auckland University, investigate the impact of performance against the SS10 target on Māori and Pacific health outcomes via an observational study to examine quality measures of ED care and mortality by ethnicity	Ongoing	
Review feedback from Pacific patients, in partnership with the Pacific team, to improve our care accordingly (EOA)	Jun 2021	
Audit and improve cellulitis pathway for Starship ED (high incidence in Pacific) clinical care and admission reduction (EOA)	Jun 2021	
Expand the cellulitis pathway through increased community follow-up with resources and education for Māori and Pacific children to reduce the risk of deterioration (EOA)	Jun 2021	
Patient experience		
Implement Starship Speak out for Safety bedside huddles to improve shared decision making with whānau in at least three acute areas	Jun 2021	
Review the patient and whānau experience collection method in Starship ED to address low response rates in Māori and Pacific (EOA)	Jun 2021	
Improving our understanding of patient experience for Māori and Pacific communities by redesigning our patient experience survey based on patient feedback gathered as part of a Patient and Whānau councils project to improve patient experience • Roll out survey	Jun 2021	

Rural health

Actions to plan and provide for the health needs of our rural population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Review the Rural Alliance Work Plan Activities and determine effectiveness of access for rural Māori and Pacific (EOA)	May 2021	
Evaluate the Rural Ferinject Pilot and use findings to support general practices to promote to rural Māori and Pacific patients to reduce the impact of iron deficiency anaemia (EOA)	May 2021	
Develop a business case to increase access to imaging services (x-ray, ultrasound) for rural populations to be equitable and timely	Jun 2021	

Healthy ageing

Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Falls and fracture prevention services • Promote, and increase enrolments in, the in-home and community strength and balance programmes • Ensure the in-home strength and balance programme is operating at capacity and agreed criteria are in place to manage any waitlist • Implement ongoing improvements in the Fracture Liaison Service (FLS) patient identification process and tracking system to ensure screening targets are being met/exceeded • Ensure patients who need bone protecting treatment are routinely offered this treatment by the FLS	Jun 2021	40% of individuals screened by the FLS are either prescribed, or a letter is sent to their GP recommending, bone protection treatment
Non-acute rehabilitation pathway (NAR) • Develop multidisciplinary intermediate care services to support NAR in community settings • Provide structured rehabilitation services in collaboration with primary car and other stakeholders to patients with complex disabilities in the community	Jun 2021	60% of stroke patients referred for non-acute stroke rehabilitation in the community are seen within 1 week of referral
Home and Community Support Services (HCSS) • Include the national service specification in HCSS contracts for long-term support for older people and amend performance monitoring reports to include measures from the national framework for HCSS • Align the HCSS case mix used by Auckland DHB with the national case mix • Investigate service delivery options to better meet the needs of Māori and Pacific and determine if a significant change to the existing HCSS arrangement is needed (EOA)	Jun 2021	
Frailty pathway • Implement an ED screening tool to identify frail older people presenting as emergencies and ensure that all patients identified by the screening tool receive a comprehensive geriatrics review • Develop a multidisciplinary Rapid Community Access Team to support frail older people in community settings	Jun 2021	50% of patients assessed on the Frailty Pathway in Emergency Department are discharged home with community support avoiding unnecessary hospital admission
Dementia Framework Develop an improved model of care for two elements of the	Sep 2020	

Healthy ageing Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016		
national framework, including identification of any new services or resources required and prioritisation of these: i) Assessment, diagnosis, early intervention, and ongoing support; and ii) Living well		
COVID-19 Response Implement actions prioritised for DHBs from the Independent Review of COVID-19 clusters in Aged residential Care	Mar 2021	

Improving quality Actions to improve equity in outcomes and patient experience		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Improving equity - Diabetes Complete the validation phase for a co-design project – based on information in the Atlas of Variation and locally collected performance data - to transform the diabetes care system. Co-design activities will focus on engaging Māori and Pacific to improve equity (EOA) • Outcomes and learnings from the validation phase summarised and disseminated to all PHOs • Evaluate co-design programme to measure impact on outcomes • Report regularly to the Diabetes Service Level Alliance	 Jun 2021 Jun 2021 Ongoing	
Improving consumer engagement Integrate the quality and safety marker implementation and reporting for consumer engagement into the Patient and Whānau Centred Council (PWCCC) work plan • Complete PWCCC orientation to QSM • Upload data to QSM dashboard • Submit twice yearly report	 Jul 2020 Ongoing Ongoing	
Implement the PWCCC communications plan designed to actively engage Auckland DHB Board/Chair, mana whenua (Te Runanga o Ngāti Whātua), ELT and other DHB consumer councils to bring the patient voice to the forefront • Use integrated patient and whānau feedback to inform the next Annual Plan	Dec 2020	
Implement strategic projects designed to improve Auckland DHB engagement with Māori, Pacific, Asian populations and those aged <18 years and >80 years in patient experience feedback methods (EOA) • Publish the new evidence-based guidance for engaging consumers from target groups on our staff intranet	Jun 2021	Establish baseline usage data on the Auckland DHB intranet consumer engagement guidance page
System Level Measures *See the 2020/21 System Level Measures Improvement Plan (Appendix D)*		

New Zealand Cancer Action Plan 2019-2029

Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Current Performance Actions		
Increase Māori and Pacific FSA attendance (HSC) Develop and implement a DNA project across all tumour streams in conjunction with Patient Administration and Cancer Psychological Support staff (EOA) • Review pilot in three tumour streams • Roll out to other tumour streams	 Dec 2020 Jun 2021	Once established, the Auckland DHB Cancer Outcomes Board will set an improvement target to reduce equity in the FSA DNA rates in Māori and Pacific patients
Cancer waiting times Continue to sustain and improve equity of access (both 62- and 31-day target performance). Includes BAU FCT activity and: • MDM streamlining process underway in two tumour streams • Complete deep dive into up to three priority areas within the 31-day target (e.g. skin, head and neck, radiation oncology)	 Jun 2021 Jun 2021	90% compliance for Māori and Pacific patients on the 62-day FCT pathway (SS11 measure) At least 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat (SS01 measure)

Bowel screening and colonoscopy wait times

Actions to meet colonoscopy wait times by actively managing demand, capacity and capability

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Colonoscopy wait times		
• Implement recovery plan including outsourcing 550 colonoscopies privately	Dec 2020	SS15 colonoscopy measures: • Urgent diagnostic (90% within 14 days, 100% within 30 days) • Non-urgent diagnostic (70% within 42 days, 100% within 90 days) • Surveillance (70% within 84 days, 100% within 120 days)
• Review scheduling and operational practices to maximise utilisation rates and reduce DNA rates	Jun 2021	<5% overall DNA rate
• Develop and implement solutions to address Māori inequities including DHB recommendations for planned care	Jun 2021	<10% Māori DNA rate by Jun 2021 (<5% Māori DNA rate by Jun 2022)
Bowel screening		
Demonstrate readiness to the Ministry of Health in preparation to roll out the National Bowel Screening Programme: Infrastructure in place including: • Project plans, key policies and procedures signed off • IT systems and E referral pathways in place • Key roles appointed to	Sep 2020	
Implement National Bowel Screening Programme: • Ministry of Health approval confirming ready for go-live	Nov 2020	

Workforce

Actions to support and improve the skills and diversity of our staff members, and improve our organisational health literacy

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Workforce including diversity • Just Culture Programme delivery: - Train union delegates - Train employment relations community of practice	Jun 2021	200 managers trained
• Develop online Just Culture Fundamentals training for all staff and launch module	Jun 2021	20% of all staff have completed module
• Implement two priority activities from the Hauora Healthy Workplace Plan	Jun 2021	100% of activities completed
• Expansion and Enrichment of To Thrive (low paid workers) programme - Implement and communicate two additional career development offerings - Offer two Basic (ESOL) Literacy and Numeracy programmes - Offer one Step Up (extended Literacy and Numeracy) programme	 Dec 2020 Dec 2020 Dec 2020	 Programmes completed (x16 learners) Programmes completed (x16 learners) Programme completed (x8 learners)
• Accessibility - Define and implement an augmented Placement Support approach - Complete audit of recruitment processes for accessibility best practise	 Jun 2021 Jun 2021	
Leadership and Development • Develop and implement a support programme for Aspiring Managers completing the Management Development Programme	Jun 2021	
• Define and implement Leadership Expectations to support equity, cultural safety and Just Culture	Jun 2021	
• Māori employees mapped to dynamic talent matrix (EOA)	Mar 2021	30% Māori and Pacific employees mapped
• Pacific employees mapped to dynamic talent matrix (EOA)	Jun 2021	
• Development/career conversations completed for Māori and Pacific employees talent and development plans in place (EOA)	Jun 2021	30% of all Māori and Pacific employees have career and development plans in place *(100% for all those assessed as high potential)*
• Design and implement Disability confidence training for managers	Jun 2021	10% of managers complete training
• Implement regional recommendations related to the: - theatres workforce review - reviews for medical imaging and cardiac workforces	Jun 2021	
• Set up workforce development-based alliances with health education providers to influence quality of training and readiness of future workforces - Explore options for micro-credentialing and optimising student clinical placements, and other models that fast track workforce readiness reviews for medical imaging and cardiac workforces - Identify and progress workforce red flag issues for the region e.g. anaesthetic assistant, MRI MRT and cardiac sonography workforces	Jun 2021	

Workforce Actions to support and improve the skills and diversity of our staff members, and improve our organisational health literacy		
• Strengthen workforce planning to enable delivery of the Northern Region Long-Term Health Plan and the short-term response to the supply and demand challenges as a result of COVID-19 - Plan for and act to secure and prepare our workforces in the post-COVID-19 setting and to support increasing demand across our vulnerable communities	Jun 2021	Target return rate: 65%
Planning for a cross-sector workforce approach to manage the impact on service delivery from matters such as COVID-19 To improve access to primary care for those at risk (homeless/transient/vulnerable people) and housed in managed accommodation (EOA): • work with housing and primary health care providers to provide nurse-led outreach health clinics for the at risk people during their stay in managed accommodation	Sep 2020	
• support the development of capacity and capability of the primary care workforce to deliver services to people at risk	Sep 2020	
• work alongside whānau ora providers and other health and social services to improve health and wellbeing of people at risk	Sep 2020	
• report on implementation of nurse-led Outreach Health clinics for people at risk	Nov 2020	
Health literacy Develop our website to ensure it better meets the needs of our communities: • review our website via a Consumer Council-led co-design process and complete priority updates • review website content against the government's web standards • use a readability testing tool to ensure website content for the public is written for reading age of 10 years • rewrite content for people with lower levels of literacy (only 16% of New Zealanders are considered to have high literacy levels) and ensure we use inclusive language • increase the use of patient stories as communications tools, featuring a diverse range of patients and whānau • all videos to contain subtitles in line with accessibility guidelines • translate key content into New Zealand sign language, Te Reo, and other languages (EOA) • review website for accessibility based on the Web Content Accessibility Guidelines (WCAG) 2.1	Jun 2021	

Data and digital

Actions to improve our information technology systems to better support healthcare delivery to our population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Insight Decision and Support Integrated operations centre (IOC) – provides integrated care with real-time dashboards to improve decision making and patient and staff safety; aligned with regional ISSP digital acceleration plan • Implement Care Capacity and Demand Management (CCDM) cloud dashboards	Jun 2021	
Patient administration system (PAS) replacement – integrated care transformation; aligned with regional ISSP and Auckland DHB risk management plan	Oct 2023	
Digital Infrastructure – improve Wi-Fi capability and coverage across agreed sites in alignment with Auckland DHB digital strategy to increase productivity and improve patient safety	Jun 2021	
Concerto clinical portal upgrade – provides integrated care; aligned with regional ISSP plan and Auckland DHB risk management plan	Aug 2020	
End of life risk management – reduce the complexity and number of different systems across the region while strengthening security, resilience and performance by working collaboratively to align product selection with Regional ISSP and regional applications • Prepare business case for Transcription Service replacement • Commence implementation of new maternity system • Replace Workforce Central with Workforce Dimensions	 Oct 2020 Jan 2021 Mar 2021	
Regional Oncology Electronic Health Record implementation – ensures equity by design; aligned with regional ISSP plan and linkage to Northern Region Integrated Cancer Service Board (NRICS) models of care change • Complete procurement • Commence implementation	 Apr 2021 Jul 2021	
Optimise - regional retinal screening solution – ensures equity by design and models of care change; aligned with regional ISSP • Implement regional solution	 Jun 2021	
Telehealth – ensures equity by design and model of care change; provides telehealth; aligned with regional ISSP • Continue to roll out Zoom and other digital technologies for virtual consultations	 Ongoing	
Digital Automation and workflow – ensures equity by design, provides remote working and increased productivity and quality; aligned with regional ISSP digital acceleration • Prepare business case for workflow and automation toolset proof of value (POV) and implement POV test case • Prepare single stage business case for selection of workflow and automation toolset and rollout capability across the DHB	 Dec 2020 Jun 2021	

Implementing the New Zealand Health Research Strategy

Actions that demonstrate a commitment to support the implementation of the New Zealand Health Research Strategy

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Apply to the Health Research Council (HRC) for: • A collaboration grant • Other health delivery grants	 Jul 2020 As available	At least two new HRC grants are secured
Sustainable careers • Secure one HRC health delivery research career award	Jun 2021	Secure $500k in new research funding via Auckland Heart Foundation
Work with the University of Auckland under our academic health alliance to develop clinical researcher capability in the DHB	Ongoing	
Core research skill • Provide a one-hour workshop on research methodologies for junior doctors	Jun 2021	
Respond to the HRC clinical trials Request for Proposal (RFP) as part of a national consortium that includes two other DHBs; if successful, develop framework and progress	Ongoing	
Identify a Good Clinical Practice tool for all staff to access	Jun 2021	
Provide progress summary update to the Ministry of Health	Jun 2021	

Refer to the He Korowai Oranga – the Māori Health Strategy table at the beginning of Section 2 for activities related to implementation of the Waitematā and Auckland DHBs' Māori Health Research Strategy

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans

Actions to support the delivery of the RSP/national service plans

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Equity Led Planned Care Recovery As part of the regional response work, support: • Rapid review of selected services resulting in proposed solutions that address equity impacts related to COVID-19 • Further refinement of proposed solutions • Regional agreement on solutions • Support implementation of solutions	 Sep 2020 Dec 2020 Dec 2020 Jun 2021	
Radiology Action Plan Work with the Northern Region radiology work programme to: • Identify current demand and capacity • Improve waiting times and optimise capacity configuration • Plan for required replacement and acquisition of additional assets • Develop and support a sustainable workforce, including enabling of international recruitment	 Sep 2020 Jun 2021 Jun 2021 Jun 2021	
Hepatitis C Collaborate with regional DHB partners to implement the clinical pathway and key priorities in the National Hepatitis C Action Plan (once the plan is published) by: • providing targeted testing of patients most at risk for HCV exposure (EOA) through point-of-care and/or community-based laboratory services • collaborating across primary and secondary care to support people with allied services (e.g. community alcohol and drug services, needle exchange, and other social agencies) best	 Dec 2020 Sep 2020	Number of newly diagnosed HCV RNAs for the Northern Region

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans Actions to support the delivery of the RSP/national service plans		
placed to support HCV diagnosis, treatment and ongoing management		
Collaborate with regional partners to increase access to primary care and promote primary care prescribing of the new pangenotypic hepatitis C treatments by • raising awareness and providing education on HCV, risk factors and management/treatment options to primary care teams, specifically NGOs and service providers with known at-risk patient populations • enhancing the delivery of an integrated hepatitis C service through community-based HCV testing and care	Mar 2021 Jun 2021	
See the Northern Regional Service Plan 2020/21 for further details		

Better population health outcomes supported by primary health care

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education. Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. We aim to improve the primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes and serving all people equitably.

Primary health care integration Actions to strengthen our district alliances, address equity gaps and improve access to primary care services		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Ensure everyone who is able to is earning, learning, caring or volunteering		
DHB activity	**Milestone**	**Measure**
Auckland Waitematā Alliance • Critical reflective review of work programme and impact on equity • Action plan to respond to recommendations addressing equity of critical reflective review • Develop an equity framework to improve responsiveness of community pharmacy services for Māori and other high needs populations (EOA)	Dec 2020 Mar 2021 Dec 2020	

Air Ambulance Centralised Tasking Actions that demonstrate active participation in the national development of centralised tasking for aeromedical assets in New Zealand		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Supporting healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
The DHB remains committed to the 10 year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this, the DHB: • will support the implementation of changed Governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, and	Jun 2021	

Air Ambulance Centralised Tasking

Actions that demonstrate active participation in the national development of centralised tasking for aeromedical assets in New Zealand

• supports the development of a robust national process to scope the requirements of a national tasking service		

Pharmacy

Actions to support the optimisation of pharmacy services

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
To support the Pharmacy Action Plan and the ICPSA, we will: • Develop the service model for Enhanced Residential Care Pharmacy services as part of the Pharmacy Service Level Alliance (Pharmacy SLA) to achieve equitable access to the pharmacy optimisation expertise of pharmacists for older people living in aged residential care facilities and community residential care facilities	Jun 2021	
• Implement the recommendations that arise from the Schedule 1 review	Ongoing	
• Provide smoking cessation service in selected local pharmacies to improve access to priority populations, e.g. Māori, Pacific, people with mental health Illnesses, pregnant women and smoking partners of (or family living with) pregnant women (EOA)	Ongoing	
• Implement key local strategies to improve access and vaccination rates to Māori, Pacific, Asian, migrant and former refugee communities (EOA)	Ongoing	
• Commission the Safety in Practice to support local pharmacists working as part of an integrated system with the key aim of working with primary care to reduce preventable patient harm and adverse drug events through quality improvement	Ongoing	
• Develop an Equity Plan for community pharmacies	Jun 2021	
• We will consider the impacts of COVID-19 on the DHB and sector's capacity to undertake the activities throughout the work programme planning	Ongoing	

Long-term conditions including diabetes

Actions to strengthen public health promotion on preventing diabetes and other LTCs, including equitable service access

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Microalbuminuria management Ensure the learning from high achieving practices is transferred to other practices to promote best practice and improve equity (EOA)	Dec 2020	90% of enrolled patients with diabetes (aged 15 to 74 years) who have an elevated ACR recorded on two consecutive occasions at least 90 days apart are on an ACE inhibitor or angiotensin receptor blocker
Diabetes Self-Management Education (DSME) Demonstrate quality improvement of DSME programmes through collection, analysis and translation of participant course evaluations	Jun 2021	
Secondary prevention of CVD Ensure the learning from high achieving practices is transferred to other practices to promote best practice and improve equity (EOA)	Jun 2021	100% of PHOs report collection of participant evaluations and applications of findings for quality

Long-term conditions including diabetes Actions to strengthen public health promotion on preventing diabetes and other LTCs, including equitable service access		
		improvement 70% of enrolled patients (aged 25 to 74 years) with known CVD are on triple therapy (statin + BP lowering agent + antiplatelet/anticoagulant) (excluding patients with history of haemorrhagic stroke)
Annual Reviews Continue reporting of Quality and Safety Performance metrics at a patient identifiable level to general practices to allow person specific, tailored and focused annual review of each person with diabetes	Quarterly - ongoing	
Refer to the Healthy Food and Drink section for DHB activities focused on the prevention of diabetes and other LTCs		

Financial Performance Summary

Statement of Comprehensive Income	2018/19 Audited Actual $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Funding						
Government & Crown Agency Sourced	1,582,373	1,687,379	1,742,995	1,809,961	1,872,292	1,979,908
Non-Government & Crown Agency Sourced	98,730	103,210	105,660	105,653	106,346	107,047
IDFs & Inter-DHB Sourced	660,368	701,179	745,417	771,233	792,847	831,389
Total Funding	**2,341,471**	**2,491,768**	**2,594,073**	**2,686,847**	**2,771,486**	**2,918,344**
Expenditure						
Personnel Costs	1,268,451	1,211,108	1,184,076	1,202,558	1,225,201	1,248,283
Outsourced Costs	141,366	155,064	153,967	156,257	159,196	164,420
Clinical Supplies Costs	302,474	308,527	326,698	337,222	345,381	354,793
Infrastructure and Non-Clinical Supplies Costs	214,417	216,629	224,496	233,336	253,672	292,452
Payments to Providers	546,962	599,022	635,023	638,138	665,311	729,608
IDF Outflows	100,167	103,143	114,856	119,335	122,724	128,787
Total Expenditure	**2,573,837**	**2,593,492**	**2,639,116**	**2,686,847**	**2,771,486**	**2,918,344**
Share of associate joint venture surplus/(deficit)	399	(150)	-	-	-	-
Net Surplus/(Deficit)	**(231,967)**	**(101,874)**	**(45,043)**	**-**	**-**	**-**
Other comprehensive income						
Gains/(Losses) on Property Revaluations	83,512	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(148,455)**	**(101,874)**	**(45,043)**	**-**	**-**	**-**

Statement of Service Performance (Four-year plan)

Prospective summary of revenues and expenses by output class	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Early detection				
Total revenue	523,688	543,222	560,333	590,031
Total expenditure	482,232	491,684	507,172	534,052
Net surplus/(deficit)	**41,456**	**51,538**	**53,161**	**55,979**
Rehabilitation and support				
Total revenue	270,810	280,911	289,760	305,117
Total expenditure	291,406	297,118	306,477	322,720
Net surplus/(deficit)	**(20,596)**	**(16,206)**	**(16,717)**	**(17,603)**
Prevention				
Total revenue	37,500	38,899	40,124	42,251
Total expenditure	65,362	66,643	68,742	72,386
Net surplus/(deficit)	**(27,862)**	**(27,744)**	**(28,618)**	**(30,135)**
Intensive assessment and treatment				
Total revenue	1,762,075	1,823,815	1,881,268	1,980,946
Total expenditure	1,800,116	1,831,402	1,889,095	1,989,187
Net surplus/(deficit)	**(38,041)**	**(7,587)**	**(7,827)**	**(8,241)**
Consolidated Auckland DHB				
Total revenue	2,594,073	2,686,847	2,771,486	2,918,344
Total expenditure	2,639,116	2,686,847	2,771,486	2,918,344
Net surplus/(deficit)	**(45,043)**	**-**	**-**	**-**

SECTION 3: Service Configuration

Service coverage exceptions and service changes are formally approved by the Ministry of Health prior to being undertaken. In this section, we signal emerging issues.

Service coverage

The Service Coverage Schedule is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability (NZPHD) Act (2000), which is subject to endorsement by the Minister of Health. The Schedule allows the Minister to explicitly agree to the level of service coverage for which the Ministry of Health and DHBs are held accountable. Auckland DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21.

Ability to enter into service agreements

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

a) negotiate and enter into service agreements containing any terms and conditions that may be agreed;
b) negotiate and enter into agreements to amend service agreements.

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

Service change

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Regional sustainable services post-COVID-19	NRHCC vulnerable services identified for scoping and action plans to be completed for implementation in 2020/21: • Oral Health specialist services streamlining patient pathway, reducing wait times and review of service locations • Review of complete oral health pathway for children including Auckland Regional dental Service	Children and adolescents receive secondary level dental care in a timely manner and closer to home	Regional and local
Re-establishment of service and change in location of services	Kaupapa Māori Forensic Step-Down Beds (regional forensic service): RFP to select a provider for replacement of 5 kaupapa Māori community residential forensic step down beds completed in 2019. Contract is under negotiation. New location will be central Auckland in the interim until a purpose-built facility is sourced. Location to be agreed by Regional Forensic Service	Replace access to a kaupapa Māori forensic step-down service	Regional (delivered by Waitematā DHB)
Change in location of services	CADS regional medical detox and Regional Social Detox service to co-locate with regional social detox service at new build in central city Auckland (Mission Homeground)	Service will be delivered within a purpose-built building and located with other complementary services	Regional
Change in funding	Primary Mental Health Services: Funding of primary mental health initiatives via Ministry of Health Access and Choice will expand a range of services throughout the Metro Auckland region. Currently pending decision of RFP outcome however clear indication of a suite of options	Significant expansion of metro-Auckland primary mental health support options for those with mild to moderate mental health and addiction requirements. Will expand models including Awhi Ora, Health Improvement Practitioners and Health Coaches	Regional
Potential change in model of service delivery	Supra Regional Eating Disorder Service (EDS): Midland DHBs originally withdrew from all elements of Suparegional EDS services except residential service and the service adjusted capacity accordingly. Midlands previously	Auckland DHB service resized for Northern region population for all EDSs, including residential services. Uncertainties regarding ongoing Midland population demand and	Supra Regional DHBs - Northern Region and Midlands Region

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	signalled an intention to withdraw from the residential service over time; engagement with them over the last 18 months confirmed we are the only provider of this service in New Zealand that can accommodate them. One of the Midland DHBs is exploring the option of delivering this service closer to home as part of their new capital build, which will likely be completed in 3-5 years. There is an ongoing need to consider a regional response to service delivery to be prepared for any potential withdrawal by Midlands DHBs in the future	potential to accommodate a residential service closer to home is expected to be clarified over time, enabling Auckland DHB to progress medium to longer term planning of residential services	
Review and change in service	Termination services: Return responsibility for first trimester abortion services from Auckland DHB to home DHBs and establish or purchase new services	Services that are safe, convenient and more accessible and acceptable to women within the legislative framework Improve the sustainability of second trimester surgical abortion services to be delivered by Auckland DHB for metro Auckland and other DHBs as agreed	Metro-regional
Change in service delivery model	Maternity Services: Consult with maternity stakeholders on options to reduce the caesarean section rate at National Women's Health	Improved birthing options for local population Promotion of normal delivery in community settings	Metro-regional (delivered by Auckland DHB)
Level of service provision	Improve clarity on the range of conditions for which pre-implantation genetic diagnosis (PGD) is provided and, subject to funding approvals, remove any waiting lists for PGD	Improved access to services Improved waiting times for services	Metro-regional (delivered by Auckland DHB)
Review and change in service	Review, enhance and undertake tender for improved youth health services	Improved range and access to services	Metro-regional
Change in model of service delivery and potential change of provider(s)	Undertake a tender for improved healthy weight support services for children under 5 years of age incorporating learnings from the second PPAL review	Improved quality of services available to support healthy weight management in preschool children	Metro-regional
Potential change in model of service delivery	Community Pharmacy: • DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and other stakeholders to develop service options, including potential options for pharmacist service delivery • DHBs will work with key stakeholders to develop the enhanced pharmacy service to achieve safe and consistent medicine distribution and management for residents living in aged-related residential care (ARRC) and community residential care (CRC) facilities. This will include a review of the number of pharmacy providers required to implement the new service model	Enhanced services for consumers More consistent and safer service for patients	Sub-regional (Auckland and Waitematā DHBs)
Capacity increase	Development of ward 51 an adult rehabilitation and integrated stroke unit (ARISU) at Auckland City Hospital • will create approximately 41 additional adult inpatient beds, planned to open in September 2020	Improved capacity to respond to acute demand Increased rehabilitation capacity	Regional/national

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Change in model of care	Implementation of the Frailty Model of Care for Older People aligned with Northern Region Long Term Investment Plan Provision of intermediate care in a community setting that enables patient management at home and in ARC facilities; screening for frailty in older patients in the emergency department with specialist assessment/management; direct admission of eligible patients with acute illness to specialist multidisciplinary care appropriate to needs	Increased capacity to manage demand and acute patient flow Improved patient experience and outcomes: reduced transfers between services, early access to specialist multidisciplinary care and better discharge planning with Community and Primary care services	Local (Auckland DHB only)
Potential change in model of service delivery	VA ECMO was historically initiated by Cardiac Surgery centres when necessary; however, a national service improvement process agreed it is more appropriate to transfer these patients to Auckland DHB preoperatively. Auckland DHB will need to assess demand and capacity implications, confirm revenue assumptions and develop a business case for investment to respond to this new referral demand. In preparation for this, we are working to implement technology to enable national cardiac surgical MDT meetings	Improved patient outcomes through delivery of care by a centre that is able to deliver the best evidence-based practise To ensure expertise is concentrated in one centre due to complexity of procedure and low volumes	National
Implementation of new service	Implementation of the procedure, left atrial appendage closure. There is new evidence to support the introduction of new technology in the management of this complex cardiac condition. This is supported by the Northern Regional Clinical Practice Committee and is currently awaiting approval from the Ministry of Health	Improved patient outcomes through provision of alternative evidence-based treatment for those patients contraindicated for oral anticoagulation and are at risk of stroke	Regional
Potential change in model of service delivery	Regional vascular service: The vascular team began preliminary conversations regarding a regional vascular service, with discussion regarding a potential hub and spoke model. These conversations are at a clinical level at this stage, with early agreement in principle from Counties Manukau and Auckland DHBs that there is merit to continue to pursue an agreed regional MOC in the long term. Assessment is taking place to understand the impact of a regional vascular service on other services that have clinical reliance on vascular services. Initially, there will be moves to develop a weekend on-call vascular service regionally	Improved sustainability of local and regional services Improved patient experience and outcomes	Local, regional
Shift in service	Head and Neck services: A regional review of Head and Neck services across the northern region was completed and the region is working together to improve the regional oversight, coordination and management of Head and Neck services for the region's population. There may be a change in location of some elements of service delivery arising from the regional planning process	Improved sustainability of local and regional services Improved patient outcomes	Regional and local
Potential change in model of service delivery	Sleep Service: Progress planning towards the development of new sleep service model based on ambulatory models in place already in New Zealand that makes the best use of available capacity and resources (including funding) to	Improved access Improved clinical and financial sustainability of regional model	Regional and local

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	increase the number of patients able to be assessed and treated		
Change in model of model of service delivery	Outpatient Services: Services are expected to review traditional models of service based on face-to-face outpatient activity and develop new models that incorporate alternative methods of delivery. Projects underway include satellite and nurse-led clinics, telehealth (telephone and video consultations, specifically for follow-ups), community-based IV infusions and patient-generated follow-ups. This work continues to be implemented throughout Auckland and Waitematā DHBs and further changes were accelerated due to the COVID-19 response. Continuing in 2020/21	Provision of more flexible, accessible patient-centred services Better use of new technology to deliver cost effective and efficient services	Sub-regional (Auckland and Waitematā DHBs)
Integration of services	Redesign and integration of diabetes retinal screening services across Auckland and Waitematā DHBs The redesigned service will take screening services out into the community at a significantly expanded range of locations and make appointment booking flexible and fitted to the needs of service users	Improved screening coverage Improved equity of screening coverage Consequent reductions in the burden of diabetic retinopathy and diabetic maculopathy	Sub-regional (Auckland and Waitematā DHBs)
Change in location	Interventional Radiology Services (IRS): Progressing the implementation of an Auckland-Waitematā DHB integrated service delivery model to support sustainable provision of IRS for the Waitematā DHB population locally	Improved sustainability Improved patient outcomes	Sub-regional (Auckland and Waitematā DHBs)
Level and configuration of services	Tertiary Services: Auckland DHB continues to consult with key stakeholders to examine existing specifications following the Child Health Tertiary services review completed in 2016 and is identifying where new models of service would deliver more efficient, affordable and sustainable tertiary services. Findings may impact on the configuration and scope of some services	More efficient and cost-effective service delivery More affordable and sustainable services	Local (Auckland DHB) Regional, national impacts
Improved local access	Local delivery of Oncology Services: Auckland region will continue to work together to increase delivery of non-surgical cancer services locally at Waitematā and Counties Manukau DHBs, with the timing and scope of services to be determined by the need for additional regional capacity From early 2020/21, the local delivery arrangements will be extended to include all elements of non-surgical cancer treatment for breast cancer, including cytotoxic chemotherapy and a five-year plan will be developed to expand local delivery to include other tumour streams	Improved local access Additional regional service capacity developed in a planned and cost effective manner	Metro-regional
Improved local access	National Peptide Receptor Radio-nuclide Therapy (PRRT) Service: To be developed and established by Auckland DHB through an alliance with the Auckland DHB Radiology Service, the Regional Cancer and Blood Service, the University of Auckland, and Clinical Support Services (Laboratory), following the funding decision by Pharmac. Auckland DHB Business Case for NZ National PRRT Service in development.	Improved access to New Zealand-based service for patients that meet the Pharmac funding criteria for PRRT Improved equity of access Additional regional and national service capacity developed in a planned and cost effective manner Reduction in requirement for patients to travel overseas to access this treatment at their own cost	National (based in Auckland DHB)

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	Planned for implementation in Q4 2020/21		
Implementation of an enhanced and regionally consistent model of care – stroke	Stroke care/rehabilitation • Revised model of care, agreed regionally - local stroke rehabilitation delivery, all ages • Proposed integrated Stroke Unit for North Shore Hospital (business case being finalised) including impact on age <65 years stroke rehabilitation (i.e. move to the stroke unit rather than Rehab Plus) • Development of an integrated stroke unit at Auckland City Hospital, business case awaiting ministerial approval due for implementation by December 2020 (timeline delayed due to COVID-19)	Streamlined pathway Equitable access to rehabilitation services Consistent quality of care delivery	Regional (some local delivery)
Improved local access	Adolescent and Young Adult (AYA) acute lymphoblastic lymphoma (ALL): The MoH National AYA Cancer Network is developing a clinical trial pathway for AYA patients nationally, which may lead to further service change in 2020/21	Additional regional and national service capacity developed in a planned and cost effective manner	Regional and national
111 additional FTEs	Implementation of Care Capacity Demand Management	Required to comply with current Nursing MECAs and safe staffing levels	National
133 additional FTEs	Additional tagged funding for Auckland Regional Public Health Services, Research studies, Cancer Services, Bowel Screening and Laboratory Services; includes all COVID-19-related funding	Required to enable delivery of these services that have dedicated additional funding	Local, regional and national
39 additional FTEs	Annualisation of demographic service growth commenced in 2019/20	Required to deliver services	Local, regional and national
60 Additional FTEs	Staff required to cover demographic growth for Paediatric Intensive Care, general medicine, logistics and Māori and Pacific Services	Required to deliver services	Local, regional and national

SECTION 4: Stewardship

Managing our business

To manage our business effectively and deliver on the priorities described in Section 2 and our Statement of Intent, we must translate strategic planning into action, with supportive infrastructure in place. We must be fiscally responsible and accountable for our assets, and spend every public dollar wisely to improve, promote and protect the health of our population.

Organisational performance management

We developed an organisational performance framework that links our high-level performance framework with daily activity. The organisational performance monitoring processes in place include our Annual Report, quarterly and monthly Board and Committee reporting of key Ministry of Health performance measures, monthly reporting against Annual Plan deliverables, weekly Ministry indicator reporting and ongoing analysis of inter-district flow performance, and monitoring of responsibility centre performance and services analysis. Performance monitoring is built into our human resource processes; all staff have key performance indicators linked to organisational performance that are reviewed annually.

Quality assurance and improvement

Auckland DHB aims to ensure the provision of safe, high quality, equitable and reliable healthcare.

Quality, safety and risk management activities are a focus and component of all services delivered by the DHB, and through all levels of the organisation from clinical services to the Board. Quality and safety resource is similarly spread throughout the organisation and is part of everyone's role. We have staff in most services with dedicated time for quality and safety activities to support their areas. In addition, we have services dedicated to quality and safety activities aiding these functions across the organisation, including the Performance Improvement team, the Patient Experience team, the Health and Safety team, the Clinical Quality and Safety Service, the Infection Prevention and Control Team, and the Simulation Centre team. There is a dedicated enterprise risk management team that assists services with risk management via a framework and governance structure.

The remit of these services encompasses patient safety, staff safety, quality assurance and improvement, risk management (across clinical and corporate areas), complaints and feedback, simulation and some organisational performance management.

Auckland DHB's quality, safety and risk activities were previously delivered separately. They are now joined in a single portfolio of services (except the Performance Improvement team). In 2020/21, we will work towards ensuring these services are integrated where possible. Their focus will be on continuous improvement through the delivery of some key, limited pieces of work in our identified focus areas:

- Improve clinical governance structures and capabilities
- Enhance the service operating model's design and communication methods
- Develop the capacity and capability to deliver local improvements, leveraging staff willingness to innovate and solve problems
- More effective use of technology and measurement to improve work experience and deliver better solutions to enhance patient care and equity
- Improve processes for organisational learning to inform improvement in quality, safety and risk
- Improve processes for quality assurance and audit
- Improve system design capability by establishing internal and external collaborations and partnerships
- Embed simulation as a key process for learning, innovation and system design
- Enhance feedback functions and the use of co-design so that patients, whānau and our communities have the skills and opportunities to contribute to quality, safety (including Kōrero Mai) and equity improvements
- Clinical Quality and Safety Programme with the aims of developing a safe and just culture; fostering an environment where high performing teams deliver safe and reliable care; and enhanced risk-informed and evidence-based decision making.

We have responsibility under the New Zealand Public Health and Disability Act (2000) to monitor the delivery of services contracted for outside of our own facilities (e.g. aged residential care). We carry out this responsibility through a number of auditing agencies and through ongoing relationship management with providers.

Risk management

Risk management is fundamental to decision making at all levels of Auckland DHB. Carrying risk cannot be avoided in delivering the outcomes and objectives expected by our stakeholders. Understanding and managing risk is critical to allowing our organisation to evolve and adapt to meet challenges and the changing environment in which we operate. Embracing risk provides upsides and limits

downsides. To limit risk inappropriately limits the scope of what we can and need to achieve, especially in areas where we seek change and where the problems are complex and the solutions are far from clear-cut, such as in addressing equity. In parallel, managing risk appropriately protects us and enhances the delivery of our objectives, including supporting the delivery of safe, equitable health and wellbeing outcomes for our patients and the communities we serve.

We will continue to update our framework, maintaining consistency with the AS/NZS ISO 31000 risk standard, enhancing our capability and meeting our changing organisational needs.

In addition, the enterprise view of our risk will continue to be revised to better capture both organisational and clinical/health delivery risks. The most critical of the identified risk areas are in funding, workforce, suitability of facilities and IT infrastructure, delivery of equitable health outcomes and our partners and partnerships.

Investment and asset management

Auckland DHB has gone through the second round of Investor Confidence Rating (ICR) in 2019 and managed to maintain the rating of B achieved in 2016. Maintaining the same rating is an achievement for the DHB given the second round reviews were more thorough and robust and involved more external assessments and moderation than the first round. The assessment tools for some of the elements were also stricter than the first time. Cabinet expects active stewardship of government resources and strong alignment between individual investments and overall government long-term priorities. The ICR assesses an agency's investment environment and is an indicator of the confidence that investors have in an agency's capability to realise a promised investment result.

Maintaining the ICR rating indicates that Auckland DHB has good, all-round strengths and a solid basis for continuing to lift investment performance. The ICR assessment presented an opportunity for us to identify current gaps in investment capability and to develop improvement initiatives. We implemented a number of improvement initiatives across the ICR elements to improve our overall investment management maturity. Some of the improvements implemented since the ICR was introduced include the following.

Asset Management

We updated our Asset Management Plan (AMP) to reflect our current assets, their condition, functionality and risks as well as the replacement profile to inform our investment programmes. We have developed and are implementing business cases that address the condition and functionality of our assets as well as to enable us to continue providing health services sustainably. We are currently working with central agencies to continue lifting the standards of asset management with workstreams covering policies, strategies, frameworks and processes.

Project, Programme and Portfolio Management

We improved our project, programme and portfolio management maturity and now have an Enterprise Portfolio Management Office supporting projects and programmes. We improved our business case development and review processes to ensure good evidence-based investment decisions. We are currently working on establishing regional business case standards to lift the quality of our business cases and investment decisions. We developed clear frameworks and governance and assurance oversight structures for effectively managing our Projects, Programmes and Portfolios to optimise investment delivery and value and to realise investment benefits. We are collaborating with other DHBs and government agencies to identify and implement further improvement initiatives.

Northern Region Long-Term Health Plan (NRLTHP)

In 2018, the Northern Region Long-Term Investment Plan (NRLTIP) was published, which set out our regional strategy. It identified the three key issues the Northern Region needs to address, with some 'next step' priorities for regional work. These next steps defined three programme streams:

- Northern Region Health Planning;
- ISSP (and implementation); and
- Capital Investment.

In 2020/21, further work will be undertaken to refine and develop our NRLTIP and progress short- to medium-term outcome quality, equity and process improvement priorities, as identified by our Regional Clinical Networks and agreed by regional executives.

This programme of regional collaborative work is delivered through regional mechanisms that function under regional oversight and governance groups.

Our local programme of regional long-term planning work is well aligned with the national guidance expectations. It also covers elements of the national priority work areas. This local long-term planning programme of work is structured around:

1. Long-Term Health Service Planning. This comprises:
    - Health planning 'design' work steams; work to clarify the desired models of care for our Region and to also outline the future shape of the Northern Region health service delivery system. This is work to identify and agree:

- The priority areas of health service delivery and models of care that need to change in our Region to ensure sustainable and equitable outcomes
- How those services should change

- Health planning 'implementation' work streams. This is work to progress the necessary changes relating to agreed priority areas of health service transformation; taking the prioritised and agreed new service delivery concepts and making them a reality.

2. 'Enabling' workstreams. This work relates to the strategic planning and the delivery of the 'enabling' capacity and capability to meet current and future health service delivery requirements. There are three Regional workstreams:
   - Workforce Strategy
   - Capital Investment
   - Information Systems Strategic Plan (ISSP) / implementation.

   These programmes plan and deliver the enabling workforce, capital and IS changes required to support health service transformations.

A regional emphasis on equity, quality and safety is woven through all the regional plan work-streams.

Shared service arrangements and ownership interests

Auckland DHB is involved in one joint venture. healthAlliance N.Z. Limited is a joint venture company that provides a shared services agency to the four Northern Region DHBs (each with a 25% share), delivering information technology, procurement and financial processing support.

Building Capability

Building IT capacity

Information systems are fundamental to our ability to meet the organisation's purpose and priorities. Our goal is for information to be easily accessible to those who need it, including patients, to support the best decisions, improve the quality and safety of care provided, and improve patient experience across the care continuum.

With our regional partners, we will continue to:

- strengthen our shared information service, with a focus on responsiveness and value
- improve access to our health data through cloud analytics and data visualisations
- participate in the Regional ISSP governance forums
- contribute to developing and implementing the Regional ISSP, including risk mitigation
- invest regionally in a reliable and sustainable technology infrastructure
- participate in national initiatives, e.g. the National Health Plan, National Health Information Exchange, National Child Health Information Platform (NCHIP) and Bowel Screening Programme
- improve the maturity of our regional cyber-security capability
- investment in electronic support of clinically led service initiatives.

See further information in Section 2, Data and digital.

Strengthening our workforce culture

Our goal is that the Auckland DHB workforce is a happy, healthy and high-performance community. Our People Plan is a key support in achieving that goal.

To deliver the best care and experience to our patients, whānau and communities, we believe we need to develop and sustain a strong organisational culture, built on the foundations of our shared organisational values, ensuring that leadership and management practices support equitable health outcomes, build constructive relationships, and make it safe and easy for people to work here. Our people promise is to provide all of our people with outstanding professional and personal development opportunities, and to champion and support our people in their own hauora and in the development of a healthy workplace.

Our actions to ensure our people can do their life's best work at Auckland DHB include:

- **Organisational Culture.** Using our strong values framework, and in partnership with our people, to understand and define the culture that supports our health equity aims, which focuses on eliminating institutional racism and utilises just culture as a framework for learning and improvement. This includes continuing to establish an inclusive culture that proactively supports and reduces barriers for our Māori and Pacific workforce. This includes sharing success stories for further adoption.
- **Diversity and Inclusion.** We will continue to support a safe and inclusive workplace for our Rainbow and Accessibility workforce.
- **Leadership and Management.** We will support our leaders and managers to develop the skills and capabilities to champion equity as an integral component of healthcare quality. We want them to be confident and capable as change leaders and able to support strong teamwork and great employee

experience. This work includes a focus on developing our Māori and Pacific emerging leaders.

- **Hauora/wellbeing.** It is of great importance that our people are supported holistically. Using evidence-based frameworks, including Te Whare Tapa Whā, we will partner with our people to deliver a range of strategies, supports and tools to support their hauora and ensure a healthy workplace, so they can feel safe, supported and cared for at work.
- **Collaboration.** We recognise and provide for Māori expertise and viewpoints in the development of our plans, workforce strategies and policies. We continue to collaborate closely with other DHBs, particularly our colleagues in the Northern Region DHBs, to ensure we take advantage of regional opportunities for workforce development and employment initiatives and activities. We are committed to working in constructive partnership with our union partners to proactively address workforce concerns.

Auckland DHB will meet all training and facility accreditation requirements from regulatory bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, Pharmacy Council and Medical Science Council.

We strive to be a good employer at all ages and stages of our employees' careers, and we are aware of our legal and ethical obligations. We are equally aware that good employment practises are critical in attracting and retaining health professionals who embody our values and patient-centred culture in their practice and contribution to organisational life. See further information in the three Workforce areas in Section 2.

Co-operative Developments

To achieve some of our key strategies, it is important to Auckland DHB to work with partners to support the development of the health workforce.

This includes, but is not limited to:

- Work strongly with our regional peers and partners to deliver the agreed actions regarding workforce development in the NRLTIP. These actions include:
  - Formalise partnerships with tertiary education providers, share workforce goals and expectations to influence and co-design learning pathways and delivery that promote greater flexibility and delivers to key gaps
  - Develop a regional ER/IR strategy to support new models of care, workforce flexibility, fair pay and employment conditions
  - Develop a regional augmented workforce strategy to provide improved digital capability and productivity
- As a significant training facility, we work alongside our tertiary education partners to optimise the experience of students when we host student placements across a range of clinical professions
- Continue to work with community and primary care providers to support community-based attachments based on need. Refine the PGY1 curriculum in respect of non-technical expertise and develop and deliver a new curriculum for PGY2
- Support our workforce to build a career pathway and options by working alongside ITOs (e.g. Careerforce) and other training providers (e.g. Edvance and 2020 Trust) to provide qualifications as well as literacy, numeracy and digital literacy programmes
- Work with state sector partners, such as Te Puni Kokare and the Ministry of Social Development, to develop health careers and employment programmes that engage our local Māori and Pacific communities
- Partner with schools in our community to provide workplace experience opportunities (e.g. the Rangatahi Programme).

Health and safety

The Auckland DHB Board and management aim to have a safe environment for our people, patients, visitors and contractors, where our health and safety obligations, risks and any harms are understood, assessed, regularly discussed, and addressed. We are committed to a positive health and safety culture, providing safe and secure facilities and the training needed to ensure workers can keep themselves safe in our workplace.

We want to understand our hazards and reduce our risks, reduce injury rates and fully support workers who experience an injury in our workplace. We are proud of our health and safety accomplishments and strive to enhance these further by:

- embedding Occupational Health and Safety (OHS) into our workplace culture
- providing ongoing education and training for staff, to ensure all staff understand and acknowledge a positive safety culture and their own responsibilities
- ensuring that all workers take reasonable care of their own health, safety and wellbeing by reporting all injuries, hazards and incidents in a timely manner
- providing pre-employment health assessment of worker health and ensuring all staff identified as at risk of an identified health hazard are monitored
- identifying improvement opportunities
- committing to comply with relevant legislation, Auckland DHB policies and procedures, codes of practice, and standards and safe operating procedures

- setting performance criteria and targets, with a focus on implementing annual health and safety plans, accurate measuring and reporting at all levels
- providing appropriate resourcing to support our OHS objectives
- continuing our work to reduce workplace violence and aggression, which is included in our Security for Safety Programme
- ensuring that worker engagement and participation is undertaken in health and safety matters with our workforce, and where appropriate, respective unions, before adopting or implementing changes that may affect our workers, visitors or patients
- ensuring that the Auckland DHB OHS system sets a good example of continuous improvement, is updated to reflect changes in the work environment, legislation or other impacts and is reviewed annually.

We will put this policy into practice by creating a culture that actively encourages good OHS practices and by applying effective policies, standards, systems, processes, and solid, quantifiable performance objectives to measure our success.

SECTION 5: Performance Measures

2020/21 Performance measures

The following table presents the full suite of Ministry of Health 2020/21 non-financial reporting indicators. This section is a Ministry requirement, but many of these measures appear elsewhere in the Annual Plan, as much of our work is centred on government priorities and these measures are useful in monitoring progress and achievement.

Performance measure		Expectation
Improving child wellbeing (CW)		
CW01 Children caries free at 5 years of age	Year 1	61%
	Year 2	61%
CW02 Oral health: mean DMFT score at school year 8	Year 1	<0.63
	Year 2	<0.63
CW03 Improving the number of children enrolled and accessing the Community Oral Health Service		
Children (0-4) enrolled	Year 1	≥95%
	Year 2	≥95%
Children (0-12) not examined according to planned recall	Year 1	≤10%
	Year 2	≤10%
CW04 Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	Year 1	≥85%
	Year 2	≥85%
CW05 Immunisation coverage	% of eight-month-olds fully immunised	95%
	% of five-year-olds fully immunised	95%
	% of girls and boys fully immunised – human papilloma virus (HPV) vaccine	75%
	% of 65+ years olds immunised - influenza vaccine	75%
CW06 Child health (breastfeeding)	% of infants exclusively or fully breastfed at three months	70%
CW07 Newborn enrolment with General Practice	Newborns enrolled with general practice by age 6 weeks	55%
	Newborns enrolled with general practice by age 3 months	85%
CW08 Increased immunisation at two years	% of two-year-olds fully immunised	95%
CW09 Better help for smokers to quit (maternity)	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking	90%
CW10 Raising healthy kids	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	95%
CW11 Supporting child wellbeing	Provide report as per measure definition	
CW12 Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS	
	Initiative 3: Youth Primary Mental Health	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population	
Improving mental wellbeing (MH)		
MH01 Improving the health status of people with severe mental illness through improved access (Mar 19 – Feb 20 baseline)	Age 0-19 years Māori Other	≥3.15% ≥6.11% ≥2.75%
	Age 20-64 years Māori Other	≥3.50% ≥10.90% ≥2.93%
	Age 65+ years	≥2.92%

Performance measure		Expectation
	Māori Other	≥3.64% ≥2.88%
MH02 Improving mental health services using wellness and transition (discharge) planning	% of clients discharged from community MH&A services have a transition (discharge) plan	95%
	% of audited files have a transition (discharge) plan of acceptable standard	95%
MH03 Shorter waits for non-urgent mental health and addiction services (0-19 year olds)	Mental health provider arm	80% of people seen within 3 weeks
		95% of people seen within 8 weeks
	Addictions (provider arm and NGO)	80% of people seen within 3 weeks
		95% of people seen within 8 weeks
MH04 The Mental Health and Addiction Service Development Plan	Provide reports as specified	
MH05 Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by the end of the reporting year (baseline is Q3 2018/19)	↓ by 10%
MH06 Mental health output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within: 1. 5% variance (+/−) of planned volumes for services measured by FTE 2. 5% variance (+/−) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day 3. actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
MH07 Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Expectation to be confirmed	
Improving wellbeing through prevention (PV)		
PV01 Improving breast screening coverage and rescreening	% coverage for all ethnic groups and overall	70%
PV02 Improving cervical screening coverage	% coverage for all ethnic groups and overall	80%
Better population health outcomes supported by strong and equitable health and disability system (SS)		
SS01 Faster cancer treatment (31-day indicator)	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision to treat	85%
SS02 Ensuring delivery of Regional Service Plans	Provide reports as specified	
SS03 Ensuring delivery of service coverage	Provide reports as specified	
SS04 Delivery of actions to improve Wrap Around Services for older people	Provide reports as specified	
SS05 Ambulatory sensitive hospitalisations	Age 0-4 years (SLM measure)	See our 2020/21 SLM Improvement Plan
	Age 45-64 years (SLM contributory measure)	≤3,635/100,000
SS07 Planned Care measures		
1. Planned care interventions	Number of interventions	TBC
2. Elective service patient flow indicators	ESPI 1 (>90% of referrals within each service are processed in ≤15 calendar days)	100%
	ESPI 2 (patients waiting over four months for FSA)	0%
	ESPI 3 (patients in active review with a priority score above the actual treatment threshold)	0%
	ESPI 5 (patients waiting over 120 days for treatment)	0%
	ESPI 8 (patients prioritised using an approved national or nationally recognised prioritisation tool)	100%
3. Diagnostic waiting times	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)	95%

Performance measure		Expectation
	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)	90%
4. Ophthalmology follow-up waiting times	No patient will wait ≥50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service	0%
5. Cardiac urgency waiting times	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency	100%
6. Acute readmissions (0-28 days)	Total population	13.1% (Dec 2019 baseline is 13.2%)
7. Did not attend rates (DNA) for first specialist assessment (FSA) by ethnicity	Māori Pacific Non Māori/Non Pacific	Developmental measure – no target
SS08 Planned Care three-year plan	Provide reports as specified	
SS09 Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus area 1: Improving the quality of identity data within the NHI	New NHI registration in error (causing duplication)	Group A >2% to ≤4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% to ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% to ≤2%
	Invalid NHI data updates	TBC
Focus area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	≥90% to <95%
	National Collections completeness	≥94.5% to <97.5%
	Assessment of data reported to NMDS	≥75%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified	
SS10 Shorter stays in emergency departments (EDs)	% of patients will be admitted, discharged or transferred from an ED within six hours	95%
SS11 Faster cancer treatment (62-day indicator)	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	90%
SS12 Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified	
SS13 Improved management for long-term conditions (CVD, acute heart health, diabetes and stroke)		
Focus area 1: Long-term conditions (LTCs)	Report on actions to support people with LTC to self-manage and build health literacy	
Focus area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
	Ascertainment	95-105% and no inequity
	HbA1c <64 mmol/mol	60% and no inequity
	No HbA1c result	7-8% and no inequity
Focus area 3: Cardiovascular health	Provide reports as specified	
Focus area 4: Acute heart service	Door to cath within 3 days for >70% of acute coronary syndrome (ACS) patients undergoing coronary angiogram	>70%
	% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and 3 months of discharge	>95% within 30 days ≥99% within 3 months
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	≥85%

Performance measure		Expectation
	In the absence of a documented contraindication/ intolerance, >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge: aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes); ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes); beta-blocker if LVEF<40% (5-classes) * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents	≥85%
	≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure	≥99%
	% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.	≥99%
Focus area 5: Stroke Services	% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	12%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	60%
SS15 Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 14 calendar days, 100% within 30 days	90% within 14 days 100% within 30 days
	70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 42 calendar days, 100% within 90 days	70% within 42 days 100% within 90 days
	70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure within 84 calendar days of the planned date, 100% within 120 days	70% within 84 days 100% within 120 days
	95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system	95%
SS17 Delivery of whānau ora	Appropriate progress identified in all areas of the measure deliverable	
Better population health outcomes supported by primary care and prevention (PH)		
PH01 Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PH02 Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period	100%
	Current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%	>90%
PH03 Access to care (Māori PHO enrolments) **PH04 Better help for smokers to quit (primary care)**	The DHB has an enrolled Māori population of 95% or above	95%
	% of PHO-enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%
Annual plan actions		
Annual plan actions – status update reports	Provide reports as specified	

Appendices

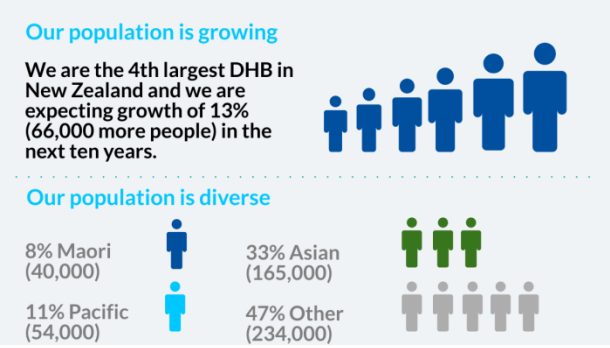
APPENDIX A: STATEMENT OF INTENT – 2019/20 to 2022/23

About Auckland DHB

Who we are

Auckland DHB is the Government's funder and provider of health services to the estimated 494,000 residents living in the Auckland isthmus and the islands of Waiheke and Great Barrier.

Auckland DHB operates the biggest teaching hospital and largest research centre in New Zealand. We provide many highly specialised services to the whole of New Zealand.



The age composition of Auckland residents is younger than New Zealand as a whole, with 37% in the 25-44 age group, compared with 28% in this age group nationally. Auckland has 12% of its population in the 65+ age group, compared with 18% nationally.

Our population is diverse and rapidly growing. 8% of Auckland residents are Māori, 11% are Pacific, and 33% are Asian. Over 45% of our population were born overseas. Our Asian population is proportionally our fastest growing population, and projected to increase to 40% of the total in the next ten years.

Auckland's population is generally healthier than that of New Zealand as a whole. We have the one of the highest life expectancies in New Zealand at 83.2 years, with an increase of 3.1 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and one in four of our adults are classified as obese (26%) (2016/17 NZ Health Survey). Our smoking rates are the lowest in the country – 9.6% are current smokers (Census 2018 Usually Resident Population).

Cardiovascular disease is the most common cause of death for residents of Auckland DHB (31%). Cancer is the second highest cause of death (27%), and there are close to 1,900 new cancer registrations in Auckland every year (excludes in-situ). Although our cancer 5 year survival ratios are among the highest in New Zealand (69%), and our CVD and cancer mortality rates are declining, a large proportion of all deaths in those aged under 75 are amenable through healthcare interventions (45% or 400 deaths in 2017).

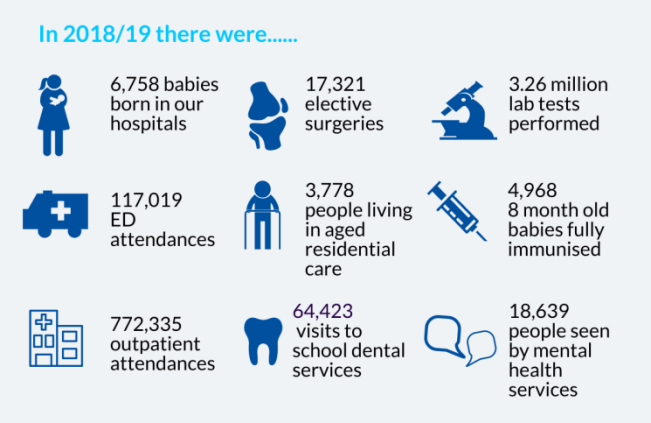
We have a similar deprivation profile to New Zealand as a whole. Almost one in five (18%) of our total population and 22% of preschool children live in the poorest areas (Quintile 5 – NZDep2013). 27% of Māori and 40% of Pacific people live in Quintile 5 areas, concentrated in Rosebank/Avondale in the west, Mt Roskill and the CBD, and the eastern and southern areas from Glen Innes to Mt Wellington and Otahuhu. These individuals experience poorer health outcomes than those living in areas that are more affluent.

What we do

Services are delivered from Auckland City Hospital (New Zealand's largest public hospital), Greenlane Clinical Centre and the Buchanan Rehabilitation Centre. We also provide community child and adolescent health and disability services, community mental health services and district nursing. Nearly 12,000 people are employed by Auckland DHB.

We have a budget of $2.6 billion in 2020/21.

Auckland DHB is unique in that we provide specialist services not available within other DHBs, including organ transplant services, specialist paediatric services, epilepsy services and high risk obstetrics. We also provide some specialist tertiary services for the other northern region DHBs, including cardiac surgery and specialist cancer services.



The key challenges we are facing

Although the majority of our population enjoy very good health and the financial performance of our organisation has been strong, a number of challenges exist as a provider and funder of health services.

Growing and aging population – the population will increase to approximately 560,000 over the next 10 years, and the 65+ year-old population will increase by more than 40%. Combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services; older people currently occupy around half of available beds.

Prevention and management of long-term conditions – the most common causes of death are cardiovascular disease and cancer, and a large proportion of all deaths in those aged under 75 years are considered amenable via healthcare interventions (45% or 400 deaths in 2017).

Health inequalities – particular populations in our catchment continue to experience inequalities in health outcomes. This is most starkly illustrated by the gap in life expectancy of 6.2 years for Māori and 7.3 years for Pacific compared with other ethnicities.

Patient-centred care – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it.

One system – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services.

Financial sustainability – the financial challenge facing the broader health sector and Auckland DHB is substantial, with the current trajectory of cost growth estimated to outweigh revenue growth by 2025. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require making some hard decisions about where we commit resource including reallocation of investment into services where we know we can achieve better outcomes.

Given the challenges we are facing we have identified three key areas of risk, and the focus needed to address these.

1. **Ensuring long-term sustainability through fiscal responsibility**

   To ensure we continue to live within our means we need to focus on:

   - Effective governance and strong clinical leadership
   - Connecting the health system and working as one system
   - Delivering the best evidence-based care to avoid wastage
   - Ensuring tight cost control to limit the rate of cost growth pressure.

2. **Changing population demographics**

   To cope with our growing and ageing population, we need to:

   - Engage patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs
   - Assist people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals
   - Increase our focus on proven preventative measures and earlier intervention.

3. **Meeting future health needs and the growing demand for health services**

   To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas:

   - Focus on upstream interventions to improve the social and economic determinants of health, within and outside of the health system
   - Providing evidence-based management of long-term conditions
   - Working as a whole system to better meet people's needs, including working regionally and across Government and other services.
   - Quality improvement in all areas
   - Ongoing development of services, staff and infrastructure
   - Involving patients and family in their care.

Our direction – a strategy to 2020 and beyond

Our **vision** is *Kia kotahi te oranga mo te iti me te rahi o te hāpori* - healthy communities; world-class healthcare; achieved together. This means helping Aucklanders to live well and stay well. At times, this involves co-designing solutions with the community to provide quality health care and support, as we do in Tāmaki. We also input into public policy, address inequities, and tackle the stressors associated with the way we live and, in some parts of Tāmaki Makaurau, the poverty in our communities. We know that the social determinants of health impact Aucklanders' wellbeing and choices. The regulatory environment can also support, or fail to support, healthy living and behaviours. Working collectively on these issues across the metro Auckland DHBs and with social sector agencies is becoming increasingly important.

As a funder and provider of services, we make sure people have healthcare services that are high quality, safe and empowering. To do this, we work across the whole system with patients, whānau, staff, iwi, communities, other health and disability providers, and social sector agencies. We are also committed to the Northern Regional Alliance long-term investment plan for both infrastructure and service redesign to meet the needs of our population in the future.

Our **values** are lived by our staff every day. They reflect our culture and the way we work, while we stand beside patients and their whānau to provide care. Our values are:

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

Link between strategy, strategic risk and strategic programmes

Auckland DHB's strategic direction is reflected in these three interrelated areas, and the table below shows their connections:

- The **Strategy for Auckland DHB** outlines the key outcomes we want to achieve and provides a framework for prioritising activity over the longer term; key strategic outcomes are taken from Auckland DHB's vision
- Our **Strategic Risks** attempt to gauge the potential impact on the organisation if we do not achieve our outcomes; these risks are identified by our Board and Finance, Risk and Assurance Committee
- The **Strategic Programmes** that will deliver the outcomes and mitigate risk in the short, medium and long term; these programmes were developed by the Executive Leadership Team and account for most of the new activity scheduled for the year (other new initiatives are proposed for 2019/20, e.g. the Sustainability, Transport, and Retail Strategies).

Strategic outcome	Strategic risk	Strategic programme
Healthy communities Achieving the best, most equitable health outcomes for the populations we serve	• Meeting our Treaty of Waitangi obligations and achieving equitable outcomes across different population groups • Providing services for our population across the whole care continuum and within budget	Mental Health Patient and Whānau-Centred Care Models of Care
World-class healthcare People have rapid access to healthcare that is reliable, equitable, high quality and safe	• Retaining high quality care and good health outcomes as demands increase • Providing the best specialist services for the rest of the country within budget • Working well and efficiently with our neighbouring DHBs • Being prepared to respond to any sudden health or infection incidents • Developing services for the future when we have immediate issues with our facilities	Building for the Future Clinical Quality and Safety Outpatients Patient Flow Provider Financial Sustainability Asset Management
Achieved together Working as active partners across the whole system: staff, patients, whānau, iwi, communities, and others	• Maintaining a great workforce culture which staff and public are proud of • Providing services in the event of any IT systems disruption or natural disasters • Keeping pace with changes in technology and expectations	People Security for Safety Information Management Systems Programme

National, regional and sub-regional strategic direction

National

Auckland DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and 'This is Our Plan – the Government's Priorities for New Zealand'. The Government's 30-year plan provides the strategic framework for developing the Annual Plan content, linking health system priorities and the whole-of-government priority outcomes.

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

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

Auckland DHB is committed to working in partnership with the Auckland Regional Public Health Service in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions. The actions in Section 2 of this plan align to the Minister's expectations and the Government's priority outcomes.

We actively work with other agencies to support at risk families and progress outcomes for children and young people, including the Ministry for Children, Oranga Tamariki. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

Regional

The NRLTIP was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed and updated to form the Northern Region Long Term Health Plan (NRLTHP). From this the annual Regional Services Plan is developed, which reflects the Ministry's identified annual areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2020/21.

Sub-regional

Auckland and Waitematā DHBs have a bilateral agreement that joins governance and some activities.

Furthermore, collaboration across the whole northern region has become increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and outcomes of health care and reduce unnecessary duplication.

Delivering on our strategy in 2020/21

Our focus for the year ahead is achieving equity for Māori and Pacific living in our district. To reduce inequities, we need to focus on long-term population health outcomes and work with other agencies to achieve this. We are increasingly aware of the societal, institutional and personal factors that contribute to inequity, disadvantage and distress. Our initial direction is to identify and understand areas where our systems and structures directly or indirectly contribute to institutional racism. In addition, we are undertaking work on short-term pipeline projects to accelerate Māori and Pacific health gain.

We support people to live well and stay well, making sure that people are informed about health and able to determine the health outcomes they want. People should have the opportunity to actively shape their care and support. We are moving towards a self-determined care approach, which allows individuals and whānau to determine what matters most to them, exercise control over their care plan, and receive the support they need from health and other agencies.

We deliver world-class healthcare and work to prevent ill health. Auckland DHB strives to uphold 'right patient, right care, right place – every time.' Providing high quality, safe and reliable care is a core strategic objective. Our Clinical Quality and Safety (CQS) Programme aims to develop a safe and just culture with the patient at the centre, where staff speak out for safety. We aim to have an environment where high performing teams deliver safe and reliable care, and robust data informs continual improvement and evidence-based decision-making.

We will implement our Mental Health Plan, which was developed to direct the changes signalled in the Government's 2018 Mental Health Inquiry.

Auckland DHB will continue to contribute to the Government's priority outcome of environmental sustainability, including reducing carbon emissions, to address the climate change impacts on health. Ongoing financial constraints remain a key challenge. Measured financial stewardship will require increasing collaboration across the three Metro Auckland DHBs and real specificity about the models of care needed to improve the quality of services for underserved populations. The strategic programmes (below) will help us to focus on the critical

areas where we need to drive change. They will advance regional aspirations in the NRLTHP and ensure that we meet the expectations of the Minister of Health.

Key programmes and initiatives

Clinical Quality and Safety

'Right patient, right care, right place – every time'. The provision of high quality, safe and reliable care every day is a core Auckland DHB strategic objective. The programme aims to strengthen our safety systems and processes, continue developing a safe and just culture with patients in the centre, and enhance leadership and capability in clinical quality improvement and safety at all levels of the organisation.

Outpatient Model of Care

This programme aims to ensure outpatient services are easy to access, easy to understand, and available at a time, place and method that meets community needs and reduces unnecessary travel to our hospitals.

Security for safety

The purpose of this programme is to strengthen security across all Auckland DHB sites to improve the safety of all staff, patients, families/whānau, visitors and contractors.

People programme

The People programme delivers on our promises to our staff; outstanding professional and personal development opportunities for everyone; to champion and support your physical and mental wellbeing, just as you do for those we serve; and transparency and fairness to ensure we can all live our values and commitments.

Āhua Awhi (Models of Care)

The programme focuses on cross-sectoral work optimising end-to-end pathways of care that integrate models of primary, secondary, community and self-care. This recognises that many of the biggest levers impacting health, wellbeing and system efficiency reside in the care provided beyond the walls of the hospital setting.

Facilities Infrastructure Remediation

This programme will minimise the risk to ongoing service delivery by ensuring critical facilities infrastructure is operational, enable future growth in capacity on our sites, improve compliance with current legislation and achieve a greater cost-effectiveness of facilities infrastructure wherever new or replacement assets are deployed. This will lead to reduced failures of critical assets and a better, safer and more sustainable environment.

Mental Health

The Ministry of Health funded Auckland DHB and our Primary Health Organisation and Non-Government Organisation partners to upscale and evaluate interventions that support people with moderate mental health needs. Our current work programme revolves around three themes: Access and choice, Equally Well, and Zero Suicide.

Building for the Future

By 2020, Auckland City Hospital is forecast to have insufficient physical bed spaces for adult patients, with limited mitigating options. This programme will plan and incrementally deliver the adult inpatient and related supplementary capacity required over the next 10 years to address the challenge and pressure of population growth on inpatient areas.

Information Management Systems and the Hospital Administration Replacement Project

This programme will strengthen and stabilise our information infrastructure to ensure continuity of service, including replacement of our Patient Administration System (PAS) as identified in the Northern Regional Information Services Strategic Plan (ISSP). The replacement will deliver a modern, fit-for-purpose PAS to enable business transformation and regional integration.

Provider Financial Sustainability

Living within our means is core to sustaining our services, and we will continue with the key priority of delivering services in a cost efficient and productive manner. This programme provides visibility and transparency over all of Auckland DHB's savings and efficiency plans linked to improving financial performance.

A new approach for 2020-2025

In 2020/21, we will develop our organisational strategy for 2020-2025. Our wider environment is changing. Financial sustainability requires us to explore self-directed care in our communities. If the future state is individuals and whānau determining their own health priorities and working with the system to supply their needs, we require a more agile and responsive health system. We need to reconsider our operating model as equity and growth in our population make existing models of care (MOC) unsustainable. We need to redesign with the community at the centre, to provide accessible and quality services close to homes and schools. We will investigate MOC developed at the margins and review system shifts to meet the needs of our diverse population. Provider arm productivity will remain a substantive focus as we seek to better understand our Māori and Pacific needs.

We have an opportunity in our 2020-2025 Strategy to advance several regional and national imperatives. Firstly, we will continue to work with our neighbour DHBs to deliver the major work streams in the Northern Region Long-Term Health Plan. While the plan pertains mostly to major capital developments, building infrastructure and

managing assets, it creates an imperative to alleviate the pressure on our hospitals by shifting more preventative, primary and secondary health services into community settings. Management attention and funding will focus on critical infrastructure risk remediation, work that allows our hospitals to function as they should. This pressure limits our attention given to strategic priorities, especially the new models of care that will ease the pressure on our hospitals downstream.

Secondly, we need to advance government priorities, notably behavioural health, child health, maternity care, midwifery and prevention. We need to increase our efforts to reduce carbon emissions and contribute to environmental sustainability.

Managing Our Business

Section 4 details how we will manage our functions and operations to deliver on our strategic intentions and maintain organisational health and capability.

Improving health outcomes for our population

Auckland DHB's performance framework demonstrates how the services that we fund or provide contribute to the health of our population and achieve our longer-term outcomes and the expectations of Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government Priorities.

We identified two overall long-term population health outcome objectives: life expectancy at birth continues to increase; and inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced. These outcome measures are long-term indicators; therefore, our aim is for a measurable change in health status over time, rather than a fixed target.

Our medium-term outcome goals and short-term priorities support these overall objectives. Equity is an over-arching priority in our performance framework and our goals focus on three priority areas: child wellbeing, prevention and early intervention, and mental health. For each measure, annual improvement milestones were set, and local progress will be tracked. Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. To help identify equity gaps and measure progress, we will monitor all medium term outcomes by ethnicity.

Child Wellbeing

We want to ensure that all children in our district have the best start to life. Pregnancy and early childhood is the most effective time to intervene to reduce inequalities and improve long term health and wellbeing.

Smoking is a leading risk factor for many diseases, and exposure to smoke during pregnancy and early childhood strongly influences health outcomes. Smoking rates among Māori and Pacific are double that of the other ethnicities and less than half of all Māori and Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the number of babies living in smokefree homes.

Pacific children, in particular, have very high hospital admission rates for conditions that can be potentially prevented or managed by primary and community care. We will improve vaccination rates and access to oral health services to help keep these children out of hospital.

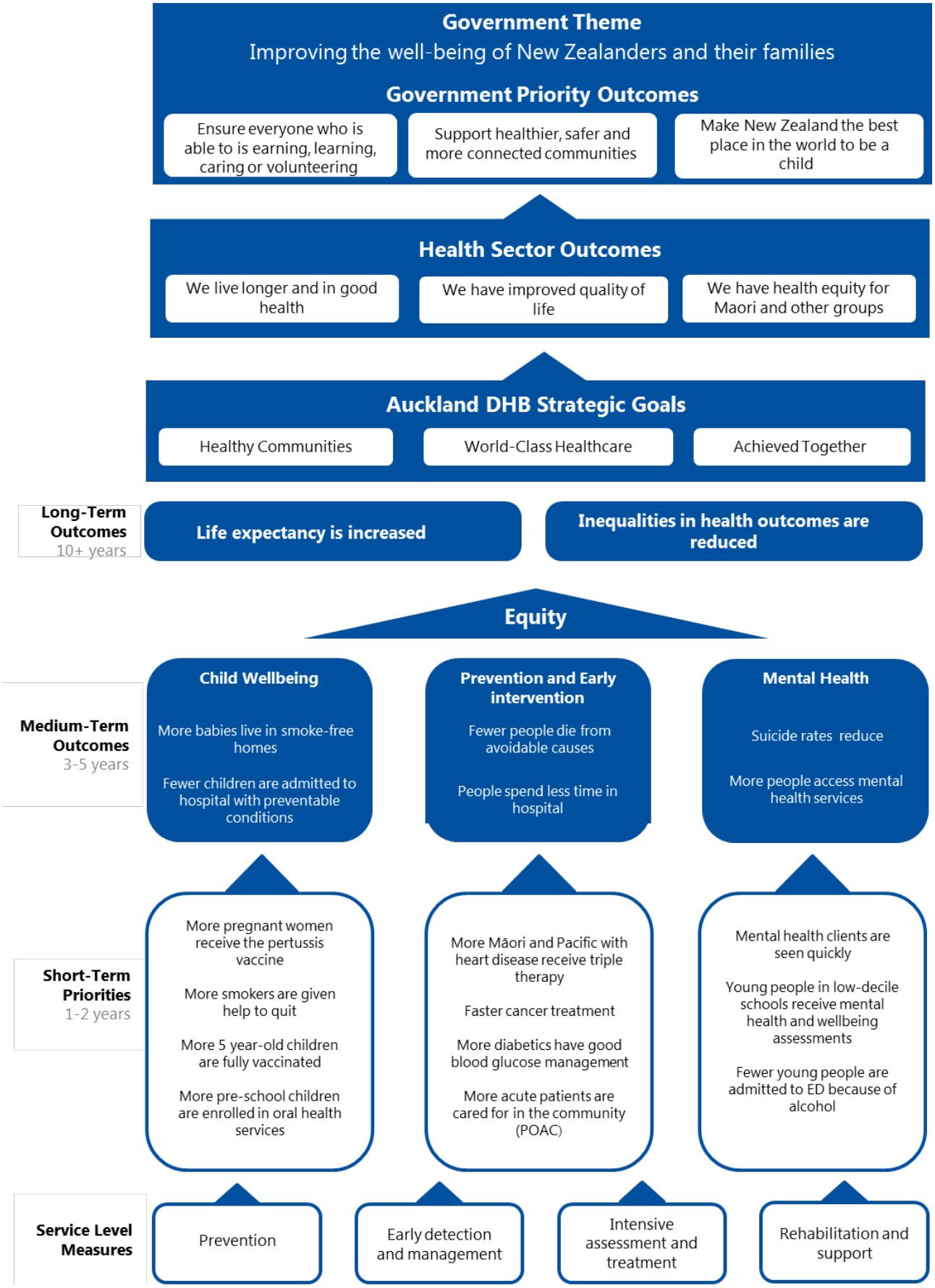
Prevention and Early Intervention

Preventative care is centred on individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Māori and Pacific have higher incidence of chronic conditions and experience poorer outcomes; we want to address this inequity. Our aim is for fewer people to die from potentially avoidable conditions. We also want to ensure that, where possible, treatment and management occurs in community settings and for people to spend less time in hospital when acutely unwell. Cardiovascular disease and diabetes rates are higher for our Māori and Pacific populations. We need to focus on good management of these conditions through support, education and prescribing of appropriate medications to improve health outcomes of those most affected. Likewise, we need to continue to ensure that our cancer pathways remain timely and without barriers to treatment access.

Mental Health

Mental health and addiction problems affect the lives of many people in our district, with around 20% experience mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We will ensure that practical help and support is available in the community to all people need it, but also that there is good access to acute mental health support when required. Young people in lower decile schools will be supported to receive help for mental health, alcohol and drug, sexual health, social and physical health issues.

Performance and intervention framework



Long-term outcomes

The long-term outcomes that we aim to achieve are to increase in life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

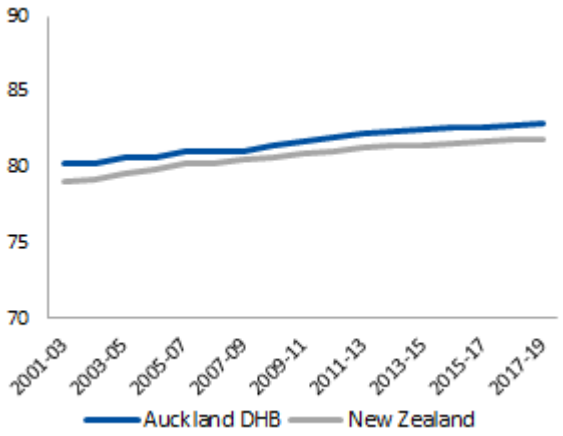
Increasing life expectancy

Life expectancy at birth is recognised as a general measure of population health status.

Overall, we have one of the highest life expectancies in the country at 82.9 years (2017-2019), which is 1.1 years higher than New Zealand as a whole. In Auckland, life expectancy has increased by 2.7 years since 2001, a similar increase to that seen across all of New Zealand.

Over the longer term, we aim to continue to increase life expectancy, and we are expecting a 2.2-year increase in life expectancy over the next decade.

Outcome Measure – Life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Reduce inequalities for all populations

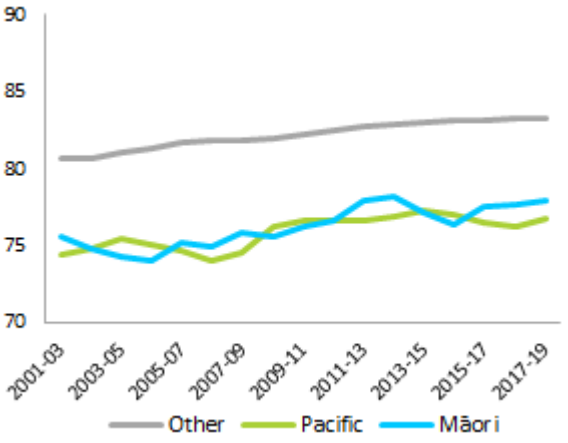
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a life expectancy lower than other ethnicities, with a gap of 6.2 years for Māori and 7.3 years for Pacific (2017-2019).

Life expectancy has increased in our Māori (2.0 years) and Pacific (2.2 years) populations over the last decade and the gap in life expectancy is gradually closing.

Higher mortality at a younger age from cardiovascular disease and cancers accounts for around half of the life expectancy gap in our Māori and Pacific populations.

We expect to see a reduction in the gap in life expectancy over the next decade.

Outcome Measure – Ethnic gap in life expectancy at birth



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Child Wellbeing

The foundations of a healthy adult life are laid in early childhood. Promoting healthy behaviours and environments, along with ensuring access to well integrated primary and community services can prevent health problems and improve health outcomes. We aim to increase the proportion of babies living in smoke-free homes and reduce the number of children admitted to hospital with preventable health conditions.

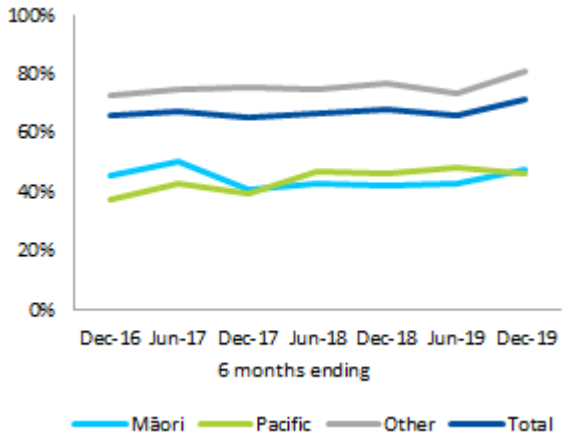
Medium-Term Outcomes

More babies live in smoke-free homes

Infants and young children are exposed to second-hand smoke more often in homes than in other places. Second-hand smoke exposure is associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure is a significant contributor to childhood health inequalities in children.

As at December 2019, less than half of all Māori and Pacific babies were living in a smokefree household in contrast to nearly three quarters of other ethnicities.

Proportion of babies living in smokefree households at 6 weeks postnatal

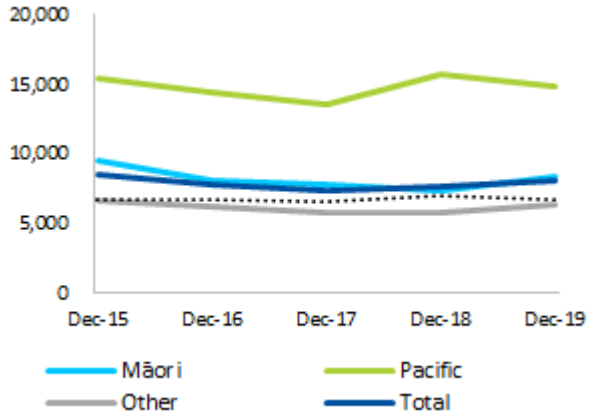


Fewer children are admitted to hospital with preventable conditions

We seek to reduce admission rates to hospital for a set of conditions that are potentially avoidable through prevention or management in primary care, known as ambulatory sensitive hospitalisations (ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

In the 12 months to December 2019, there were 2,058 admissions in 0–4 year olds that were potentially avoidable. The overall rate of admissions (7,989 per 100,000) has declined slightly since 2015. Compared with other ethnicities, rates are higher in Māori (8,407 per 100,000) and over twice as high in the Pacific population (14,836 per 100,000).

Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



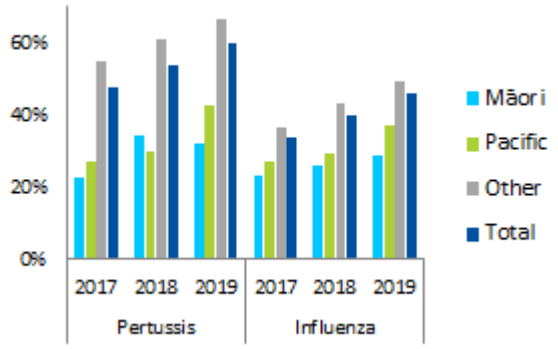
Short-Term Priorities

More pregnant women receive antenatal immunisations

Respiratory conditions are the largest contributor to ASH rates in Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants that can lead to further respiratory complications. Both are vaccine preventable, and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2019, only 53% of mothers received a pertussis vaccination during pregnancy and 39% received an influenza vaccination, with rates much lower for Māori and Pacific.

Proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy

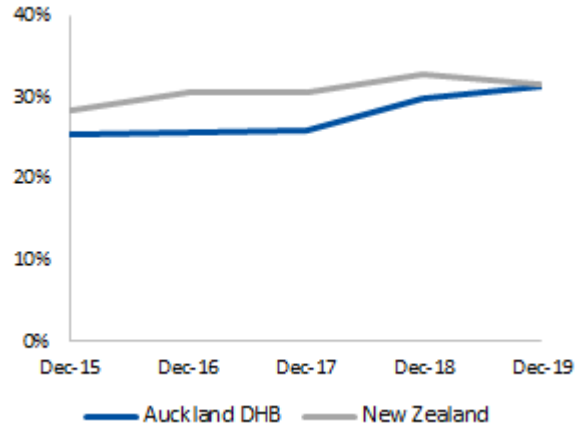


More smokers are given help to quit

Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.

Providing smokers with brief advice to quit increases their chances of making a quit attempt. The likelihood of that quit attempt being successful increases if behavioural support, such as a referral to quit smoking services, and/or pharmacological smoking cessation aids are provided.

Proportion of smokers receiving cessation support in primary care

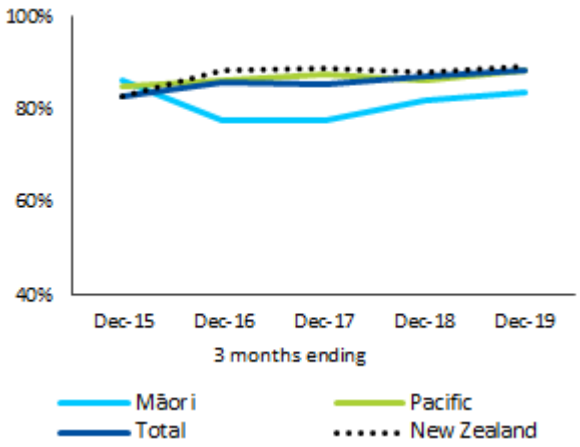


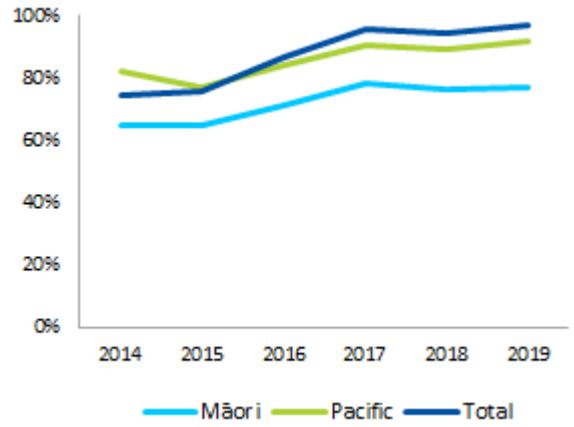
More five year-old children are fully vaccinated

Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and even death. Immunisation protects not only the child, but others that are unable to be vaccinated, via herd immunity.

Receiving scheduled vaccinations provides a good opportunity for children and families to engage with health services on a relatively regular basis.

Proportion of children fully vaccinated by five years of age

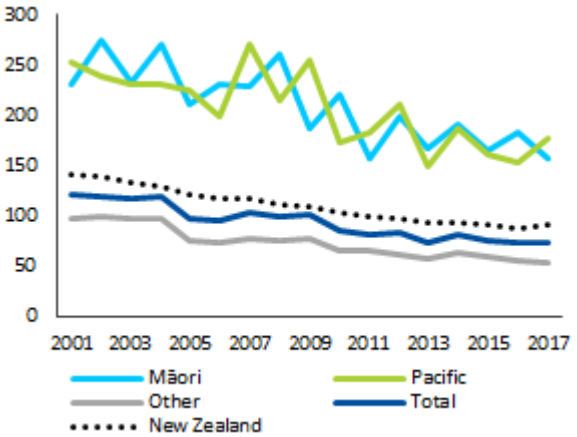


More pre-school children are enrolled in oral health services	
Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry on into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions. Dental care for preschool children is free; however, a large number of children are not enrolled in oral health services. We aim to ensure that all children are enrolled in oral health services and receiving dental care.	**Proportion of pre-school children enrolled in oral health services** 

Prevention and Early Intervention

Chronic diseases are the leading cause of death and disability, with increasing prevalence linked to increasing health costs. Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Identifying and preventing potential problems downstream, such as addressing the socio-economic determinants of health, is one strategy to improve health outcomes. When people do become unwell, prompt diagnosis and early intervention in the initial stages can have significant impact on the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for people spend less time in hospital when they are acutely unwell.

Medium-Term Outcomes

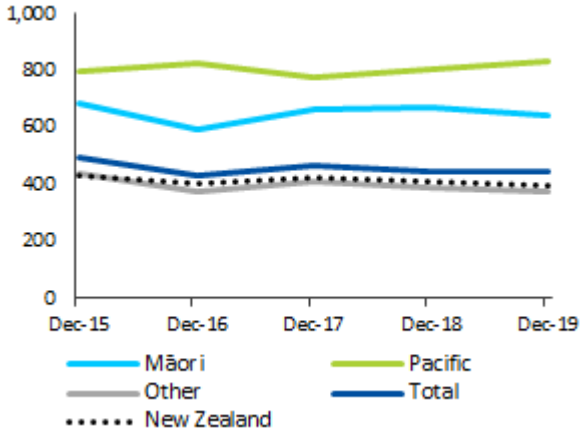
Fewer people die from avoidable causes	
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist. In 2017, we estimate that 400 deaths (45% of all deaths in those aged under 75 years) in Auckland DHB were potentially amenable. The rate of amenable mortality is currently 72.8 per 100,000 population.	**Mortality rate from conditions considered amenable, per 100,000 population** 

People spend less time in hospital

Acute admissions account for approximately half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities. Reductions may result from effective management in primary care, optimising hospital patient flow, discharge planning, community support services and good communication between healthcare providers.

Our standardised rate of acute bed days (442 bed days per 1,000 population) is slowly declining , but is ten percent higher than the national rate.

Acute hospital bed days per 1,000 population



Short-Term Priorities

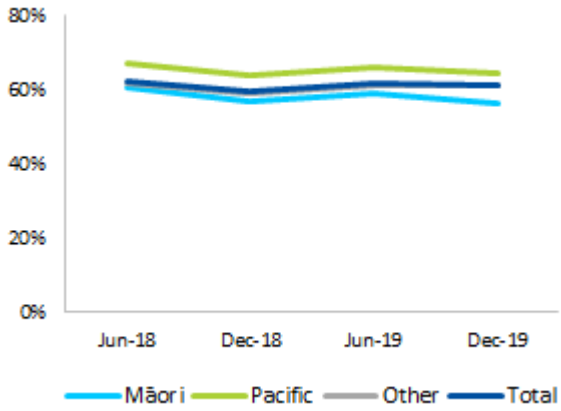
More Māori and Pacific with heart disease receive triple therapy

New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke are treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/ anticoagulant agent, a beta-blocker and a statin).

We aim to ensure that all of our patients who have had a CVD event are receiving the best possible care.

Currently, 56% of Māori and 65% Pacific who have had a CVD event are prescribed triple therapy medication.

Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy

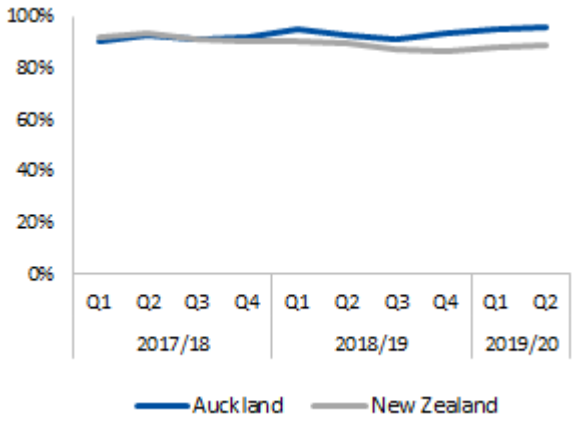


Faster cancer treatment

Cancer is a leading cause of morbidity and mortality in Auckland DHB, accounting for over one quarter of all deaths. Prompt investigation, diagnosis and treatment increases the likelihood of better outcomes for cancer patients, and assurance regarding waiting time can reduce the stress on patients and families at a difficult time.

We aim to ensure that patients diagnosed with cancer receive their first treatment or other management within 62 days.

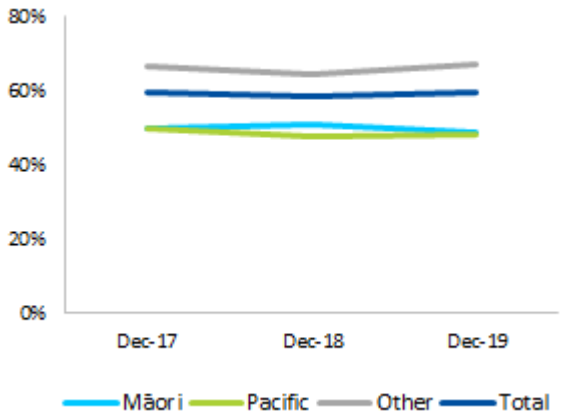
Proportion of cancer patients receiving treatment within 62 days of referral



More diabetics have good blood glucose management

The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to self-manage their condition and make lifestyle changes. HbA1c is a measure of an average blood glucose (average blood sugar) level over the past few months and can be used as an indicator of a patient's diabetes control. Well managed diabetes decreases the onset and progression of microvascular complications such as retinopathy, nephropathy and neuropathy.

Proportion of diabetics with good blood glucose management

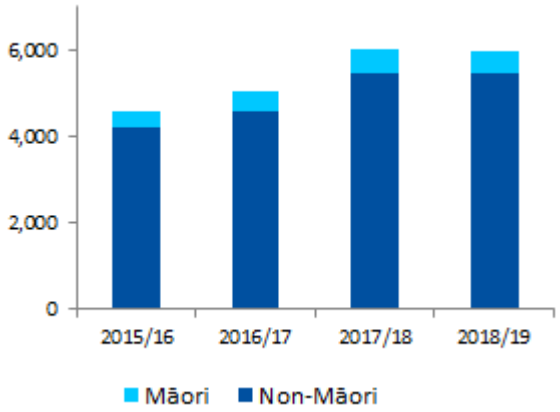


More acute patients are cared for in the community (POAC)

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevents an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting.

We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

Number of POAC referrals



Mental Health

Mental health and addiction problems affect the lives of many people in our district. Each year, around one in five of our population experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition, New Zealand has persistently high suicide rates. Improving mental health outcomes of our population does not lie solely with the health system; there are clear links between poverty and poor mental health. We aim to ensure that practical help and support is available in the community to people need it; our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

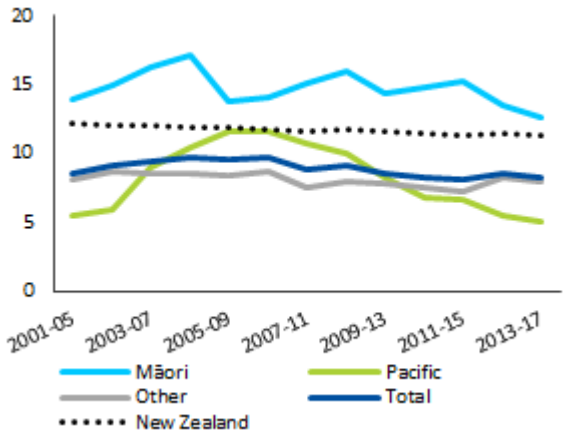
Medium-Term Outcomes

Suicide rates reduce

Suicide is a serious health and social issue. Suicide rates are a sign of the mental health and social wellbeing of the population. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress.

Although our suicide rates are lower than the national rate, it is unacceptably high, and our long-term aim is for zero suicides. Reducing suicide rates requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants.

Rate of suicide per 100,000 population

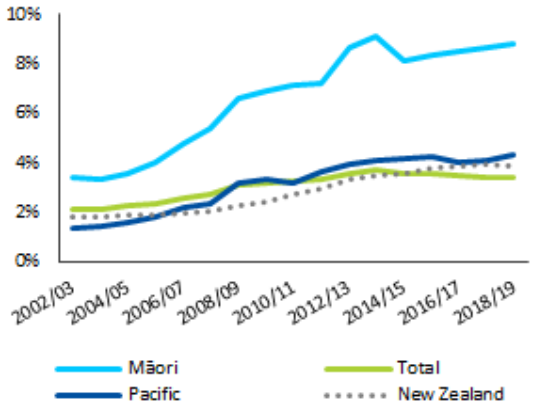


More people access mental health services

Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. While not all individuals with mental health and addiction challenges needs or will seek to access a specific service intervention, over time, more people should be able to access support. Given the current prevalence, the expected access rates should be higher than the current 3.4%.

Note: the data in this graph has not yet been updated to reflect the 2019 population projections

Proportion of population accessing mental health services – all ages



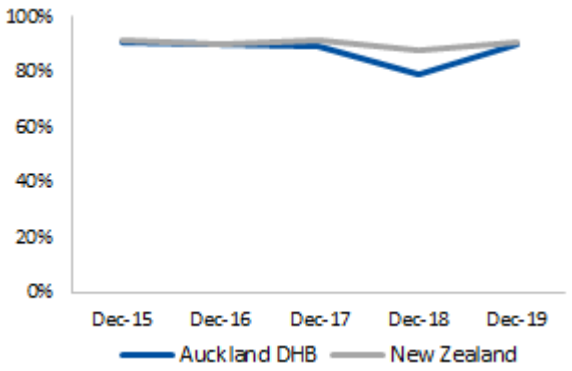
Short-Term Priorities

Mental health clients are seen quickly

Individuals experiencing mental distress or with mental health needs do not always require a referral or access to specialist mental health services. However, where a need does arise and people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options, which may include a referral to specialist mental health services.

We aim to ensure that when individuals are referred to specialist mental health services, they are seen quickly.

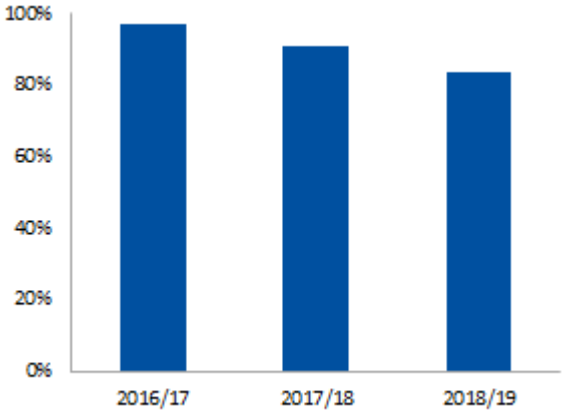
Proportion of referrals to mental health services that are seen within eight weeks



Young people in low-decile schools receive mental health and wellbeing assessments

Adolescence is a challenging time when many emotional and physical changes take place. Most adolescents make it through their teenage years and enter adulthood without major trauma. However, for some teenagers this may be a very dangerous time of experimentation. HEEADSSS is a validated assessment tool that is commonly used to help assess youth wellbeing through a series of questions relating to home life, education/employment, eating, activities, drugs, sexuality, suicide/depressions and Safety. The tool is administered to year 9 students in a number of schools and provides a mechanism for health professionals to evaluate young people's developmental stage, risk taking behaviour, risk and protective factors for them and the environment around them.

HEEADSSS assessment coverage



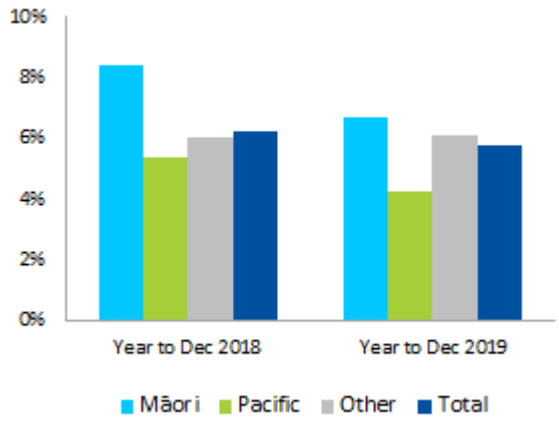
Fewer young people are admitted to ED because of alcohol

Alcohol is deemed the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand*.

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. It is a starting point to encourage DHBs to move toward screening that is more extensive, brief intervention and referrals (including to primary care and community care).

* Connor J, Kydd R, Rehm J, Shield K. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency; July 2013.

Proportion of youth Emergency Department presentations which were related to alcohol



APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS – AUCKLAND DHB 2020/21

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for 2020/21. Recent actual performance is used as the baseline. The Crown Entities Act 2004 requires the SPE to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. Our forecast financial statements for the year ended 30 June 2021 (Appendix C) and the Financial Performance Summary table (Section 2) form part our 2020/21 SPE.

Measures in our SPE represent those outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent (Appendix A), and provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators.

Statistics New Zealand and the Ministry of Health recently released updated population estimates and projections using new methodology. This had a significant impact on the population figures for Auckland DHB, with substantially fewer people living within the DHB boundaries according to these new figures compared with previous estimates and projections. This will in turn have a substantial impact on performance against those measures that use DHB population as denominator. Going forward, there may be marked changes in both current results and trend information.

Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in our Annual Report and audited at year-end by our auditors, AuditNZ.

Performance measurement framework

Our focus for 2020/21 is on delivering the key targets identified in our performance framework, which will ultimately result in better health outcomes for our population, measured by our two high level outcomes:

- an increase in life expectancy
- a reduction in the ethnic gap in life expectancy

The measures in this section link to the national, regional and local strategic direction covered in our Statement of Intent.

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. We use a grading system to rate performance against each measure. This helps to identify measures where performance was very close to target versus those where under-performance was more significant. The criteria to allocate grades are as follows.

Criteria		Rating	
On target or better		Achieved	
95–99.9%	0.1–5% away from target	Substantially achieved	
90–94.9%*	5.1–10% away from target*	Not achieved but progress made	
<90%	>10% away from target**	Not achieved and no progress made	

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

Key to output tables

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

Output class 1: Prevention Services

Preventative services protect and promote health by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services include: health promotion to prevent illness and reduce unequal outcomes; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services, e.g. immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention can significantly improve health outcomes. The DHB works with the Auckland Regional Public Health Service to promote and protect wellness and prevent disease.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	89%	90%
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking	C	98%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	95%	110
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	100%	95%
Number of clients engaged with Green Prescriptions	V	4,398	4,250
% of clients engaged with Green Prescriptions - *Māori* - *Pacific* - *South Asian*	C	 *13.1%* *21.2%* *17.4%*	 *11%* *17%* *18%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy - *Māori* - *Pacific* - *Asian*	C	 34%[6] 30%[6] 62%[6]	50% (or maintain if >50%)
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness - *Māori* - *Pacific*	C	17% 9% 12%	15%
% of eight months olds will have their primary course of immunisation on time - *Māori* - *Pacific*	C	94% 84% 92%	95%
% of five year olds will have their primary course of immunisation on time - *Māori* - *Pacific* - *Asian*	C	89% 89% 86% 91%	95%
Rate of HPV immunisation coverage	C	74%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	64%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	62%	80%
HEEADSSS assessment coverage in DHB funded school health services	C	84%[7]	95%
% of 4 year olds receiving a B4 School Check	C	89%	90%
Proportion of newborn babies offered and received completed hearing screening within 1 month	V	96%	90%

[6] CY2018 births
[7] 2019 academic year

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Auckland Regional Public Health Service[8]			
Number of tobacco retailer compliance checks conducted	V	432	300
Number of alcohol license applications and renewals (on, off club and special) that were inquired into	V	3,010	Ω
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification	Q	83%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	89%	95%
% of compliance assessments conducted of large and medium networked drinking water supplies	Q	100%	100%

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Primary health care			
Rate of primary care enrolment in Māori	C	74%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	5,984	6,036
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices who does not have an HbA1c in the last 15 months - *Māori* - *Pacific*	C	9.6%[9] 13.4%[9] 12.0%[9]	<12.0%
% of people with diabetes aged 15-74 years and enrolled with Auckland DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol - *Māori* - *Pacific*	Q	61%[9] 50%[9] 49%[9]	65%
% of Māori patients with prior CVD who are prescribed triple therapy	Q	59%[9]	70%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds: - *Māori* - *Pacific*	Q	3,507 6,880 8,791	<3,709 <6,881 <8,317
Pharmacy			
Number of prescription items subsidised	V	7,073,711	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	31,562	Ω
Number of community laboratory tests	V	3,408,529	Ω
Oral health[10]			
% of preschool children enrolled in DHB-funded oral health services - *Māori* - *Pacific* - *Asian*	C	97% 77% 92% 93%	95%

[8] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[9] As at Q4 2018/19
[10] All oral health measures have CY2019 data as baseline.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - *Māori* - *Pacific* - *Asian*	Q	0.63 0.81 0.93 0.59	<0.63
% of children caries free at five years of age - *Māori* - *Pacific* - *Asian*	Q	58% 46% 30% 55%	61%
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	TBC	85%

Output Class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as diagnostic, therapeutic and rehabilitative services. Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Acute services			
Number of ED attendances	V	121,946	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	91%	95%
Rate of alcohol-related ED admissions for 15-24 year olds	Q	14%	↓
% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	T	93%	90%
% of potentially eligible stroke patients thrombolysed	C	13%	12%
% of ACS inpatients receiving coronary angiography within 3 days	T	84%	70%
Maternity			
Number of births in Auckland DHB hospitals	V	6,594	Ω
Elective (inpatient/outpatient)			
Number of planned care interventions	V	New indicator	TBC
% of people receiving urgent diagnostic colonoscopy in 14 days	T	95%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	59%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0.6%	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	93%	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	71%	90%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	86%	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.26	<0.25
% of older patients assessed for the risk of falling	Q	81%	90%
% of falls risk patients who received an individualised care plan	Q	79%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 1,000 admissions	Q	9.5	<9.7[11]
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision	Q	98%	100%

[11] Sep-14 to Dec-19 national median.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Quality and patient safety			
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision	Q	98%	100%
% of hip and knee procedures given right antibiotic in right dose	Q	97%	95%
Surgical site infections per 100 hip and knee operations	Q	1.24	<0.97[12]
% of respondents who rate their care and treatment as very good or excellent (Auckland DHB survey)	Q		
• Inpatients		86%	90%
• Outpatients		90%	90%
Mental Health			
% of population who access Mental Health services[13]	C		
- Age 0–19 years		3.2%	≥3.15%
- *Māori*		6.2%	*≥6.11%*
- Age 20–64 years		3.6%	≥3.50%
- *Māori*		10.8%	*≥10.90%*
- Age 65+ years		2.8%	≥2.92%
- *Māori*		3.5%	*≥3.64%*
% of 0-19 year old clients seen within 3 weeks	T		
- Mental Health		66%	80%
- Addictions		82%	80%
% of 0-19 year old clients seen within 8 weeks			
- Mental Health		94%	95%
- Addictions		100%	95%

Output Class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Home-based support			
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI)	Q	96%[14]	95%
Palliative care			
Number of community contacts (nurses)	V	7,265	Ω
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	2%	<5%
Residential care			
ARC bed days	V	952,854	Ω

[12] Sep-15 to Sep-19 national media
[13] Target set using March 2019 – February 2020 data
[14] Q4 2018/19

APPENDIX C: FINANCIAL PERFORMANCE

Financial Management Overview

Our organisational vision is Healthy Communities, World-class Healthcare, Achieved Together. This vision will be achieved by working with our strategic partners and stakeholders across the whole system, including our staff, patients, customers, suppliers, shared service agencies, providers and communities, to deliver high quality, effective, efficient and safe services that will achieve the best outcomes for the populations we serve. Effectively managing our financial, human, assets and other resources is critical to long-term financial sustainability and overall progress towards our vision.

Significant steps have been taken to manage cost growth at Auckland DHB. A comprehensive savings programme delivered over $280M savings to date since its inception in 2012/13. This, combined with good financial management, has seen the DHB generate surpluses for eight years since 2011/12 as shown in the table below. However, costs continuing to increase at a faster pace than funding growth, combined with the increase in staff liabilities due to non-compliance with the Holidays Act have put the DHB financial sustainability at risk.

	2011/12 Actual $'000	2012/13 Actual $'000	2013/14 Actual $'000	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Actual $'000	2019/20 Budget $'000	2019/20 Forecast $'000
Net Surplus/(Deficit)	736	154	264	355	2,872	3,162	1,013	(231,968)	(20,000)	(101,874)

The deficit of $232M realised in 2018/19 is primarily due to the provision made for the Holidays Act non-compliance. The deficit of $20M that was planned for 2019/20 reflects disparity between funding growth and expenditure growth, with significant step increases in costs occurring in the year due to MECA settlements (partially offset by additional funding). The $101.9M deficit forecast for 2019/20 is worse than plan, mainly due to the impact of unfunded net COVID-19 costs $26.3M and an increase in the provision for the Holidays Act liability of $60.8M. The underlying DHB financial performance when excluding these extraordinary items is favourable to the budget.

Financial Sustainability

For years, we have maintained a financially stable position and lived within our means through a deliberate financial sustainability strategy that has generated savings in excess of $280M. This involved the below.

- Prioritising work programmes to get the best health service and outcomes for the local, regional and national population that we serve.
- Investing in sustainable programmes to enable us to deliver strategic change across the continuum of services we provide (primary, secondary and tertiary) to achieve our vision for **Healthy communities - World-class healthcare - Achieved together**.
- A culture of financial responsibility, accountability and discipline, supported by continuous improvement to ensure that our activities and investments add value to our patients and stakeholders, improve productivity and efficiencies, reduce waste and enable us to realise benefits of investments.
- Encouraging our people to identify areas of improvement and innovation in our processes, systems and models of care, applying our organisational values and maintaining a strong focus on delivering the best care for our patients, clients and customers.
- Working with our regional counterparts to harness the capacity and capability for solving problems together including savings opportunities, service changes and models of care.
- Working regionally to ensure that our local and regional service demand/capacity gaps and asset related risks are well understood locally and by central agencies. Developing plans to remediate risks, increase capacity, improve technology and implement changes in models of care on a timely basis. We developed the first Northern Region Long Term Investment Plan (NRLTIP) which describes our immediate and long-term capacity requirements for the northern region given regional population demographics (growing and ageing population), projected growth in demand and capacity stock take analysis. The NRLTIP also describes the regional ISSP Key investments required across the region to replace existing assets, address risks of ageing technology, facilities and infrastructure, address quality and compliance issues, increase capacity and improve efficiencies are articulated in the NRLTIP.

Key investment programmes developed and under development to address these risks and requiring Crown funding support include the below.

1. **Facilities Infrastructure Remediation Programme (FIRP).** This investment addresses significant risks of ageing critical infrastructure, the need to increase resilience and enable future facility capacity expansion required at our main hospital campuses to meet future service growth. A comprehensive expert assessment of the condition and risks of our infrastructure assets was completed to inform the remediation programme. The $1B programme business case was approved by the Ministers of Health and Finance (joint Ministers). Tranche One Business Case costing $305M and Tranche 2 business case with a cost of $262M were both approved by joint Ministers and are under implementation.
2. **Building for the Future Programme (BFTF).** This investment will deliver additional capacity required in clinical and support services for the next ten years as outlined in the NRLTIP, thereby ensuring sustainability of Auckland DHB service delivery. Additional capacity is driven by the growing and ageing population for Auckland metro, exerting significant pressures on most health services, with shortfalls projected in inpatient acute beds, operating and interventional rooms, diagnostic suites, cancer care and critical care. The Integrated Stroke Unit costing $30M approved by the joint Ministers is now nearing completion by October 2020. This project will deliver additional capacity needed in the short term. A business case to increase Operating Theatre capacity approved by the Auckland DHB Board and endorsed by the region is seeking Crown funding. The full BFTF Programme Strategic Stage Case (with an estimated cost of $1.3B) has also been developed and approved by the Auckland DHB Board and will require Crown funding to implement.
3. **Auckland DHB's PICU/ICU Child Health Expansion:** This investment is part of the BFTF Programme and aims to increase Paediatric Intensive Care Unit (PICU) capacity (an additional 10 beds) at Starship Hospital with a combination of Intensive Care Unit (ICU) and High Dependency Unit (HDU) care beds and improved spaces to accommodate whānau of children in PICU and staff. PICU is the national paediatric intensive care service for all children in New Zealand, with a current capacity of 22 physical bed spaces (16 ICU and 6 HDU). The business case for this has been developed and submitted to the Ministry for approval, with a total capital outlay of $40M proposed to be financed by Crown Equity ($25M) and Starship Foundation donations ($15M).
4. **Hospital Administration System Replacement Programme (HARP).** This investment will replace antiquated information systems and technology to ensure sufficient resilience and capacity to support the services we provide. HARP is premised on comprehensive risk assessment undertaken on the DHB's clinical and business applications, which produced a Risk Heat Map. From this work, combined with regional ISSP and NRLTIP work, Auckland DHB developed a stabilisation programme (under implementation), prioritising investments to address immediate risks while the long term solution is being developed through the business case for HARP. The business case, with an initial capital outlay of $55M has been submitted to the Ministry for Crown funding support.

Auckland DHB is at the peak of its investment life cycle, requiring significant investments such as the above to address capacity, condition, compliance and functionality related risks associated with its current asset base and future needs. The DHB requires the support from the Crown to enable it to afford both the capital and operational impacts of these investments.

We also invest in baseline asset replacement, upgrades and refurbishments using internally generated cash. As assets are a key enabler for the delivery of health services, we have been increasing our maturity in good practice asset management and now understand our assets, their condition, risks and functionality better. We have developed asset replacement plans and these indicate a bow wave of clinical equipment assets that need to be replaced over the next five years. Part of the bow wave is due to previous prioritisation of our internally generated cash to meet capital needs not only for baseline asset renewals, but also to meet capacity increase, technology improvement and to address quality and compliance issues. Crown funding support will be required to address the bow wave in a timely manner. A capital bid for Crown funding of up to $60M to address the clinical equipment backlog was not successful. Work will be undertaken during the coming financial year to develop a business case to address the clinical risks associated with this.

We are working with our regional counterparts on service development and investment planning to address our capacity gaps, deliver better outcomes for our population, ensure investment decisions are robust, services are not duplicated unnecessarily and, to ensure coherent planning for resources we compete for (e.g. workforce, contractors, funding).

Unfunded operational impacts of capital projects exert pressure on the DHB's ongoing ability to meet its obligations to patients, staff, suppliers and funders and, the ability to maintain and manage its assets, which are a key enabler for health service delivery. Given the critical nature and importance of services we provide to our population, regionally and nationally

as provider of last resort, the deficit needs to be addressed with urgency. We are committed to and have been putting tremendous effort to develop turn around strategies to bring us back to a sustainable path and breakeven position. Our context is described in the following sections.

Financial Planning Setting

We have been able to live within our means in the past by containing cost growth through process and system improvements, contracting, procurement, cash management, revenue maximisation, staffing mix strategies and various one-off savings, delivering most of the easy to implement savings in excess of $280M over the past few years. Short term savings are not possible to bridge the funding/cost gap especially considering the significant step increase in costs following the employment agreement settlements and other cost pressures. We understand the key drivers for the position we are in and have strategies for the internal elements that are within our control (such as productivity, efficiencies, process improvements and cost effectiveness) which we will work on with our staff, shared services, other DHBs, our suppliers and stakeholders.

A partial correction of the previous cost/price anomaly implemented in 2020/21 with an uplift on national prices has assisted in addressing a systemic issue relating to the national prices not fully reflecting the true cost of providing services. Auckland DHB is impacted significantly by the partial implementation due to the significant level of IDFs provided for the rest of the nation. $25M of the deficit in 2020/21 relates to the partial implementation of the price uplift.

Auckland DHB has also been impacted by the rebalancing of funding based on PBFF as our population is said to have been historically overstated. This means that our funding base is overstated and to address this, we will not be receiving additional demographic growth funding until we repay the transitional funding of $106M over the next 3 to 4 years. Part of our out-year deficits are a result of this.

We will continue to work at a local level, with central agencies and other DHBs in the region and nationally to address any structural deficits relating to national funding mechanisms, cost/pricing gaps and service demand related impacts on revenue and costs for tertiary and national services. We are also willing to work with all interested parties to address systemic issues, inefficiencies, inequities, risk/benefit trade-offs and to develop a commissioning approach to national and tertiary services that are appropriately funded. Key issues include the below.

While services we provide benefit the people we serve, having unresolved funding issues places tremendous strain on our ability to live within our means and to explore innovation opportunities. The impact to Auckland DHB of not fully implementing the pricing uplift means that Auckland DHB is expected to continue to subsidise costs for delivering services to other DHBs' populations at the expense of the population domiciled in our area.

Key Assumptions for Financial Projections

Revenue Growth

Most of Auckland DHB's revenue is from the Ministry of Health, mainly population-based funding (PBFF) for the Auckland DHB population, IDF revenue (for services delivered for other DHBs' populations) and funding for the national services we provide.

- The Ministry of Health funding for 2020/21 is based on the Funding Envelope advice provided to DHBs in June 2020 and any subsequent updates received thereafter.
- For the out-years, we have not assumed any funding for demographic growth except for the fourth year, even though our demographic growth is estimated at 2% per annum. This is due to the advice that our population has been historically overstated, as such we are in transition to rebalance to the sector PBFF allocation basis. We have assumed 2.8% cost pressure adjuster as advised in the envelope, with an increase in the pricing uplift in 2021/22 as this was not fully implemented in 2020/21.
- We have assumed that the balance of the price uplift funding will be provided in the 2021/22 financial year and is sustained to outyears.
- All other funding is based on contracts or estimated uplifts/reductions based on historical analysis.
- Any capital charge increases relating to projects approved by the Ministers are assumed to be cost neutral (i.e. fully offset by additional Ministry of Health operational revenue). Revenue to offset the capital charge impacts has been assumed in the plans.
- No additional revenue has been assumed for COVID-19 impacts. Any additional costs relating to this are assumed to fully offset by additional Ministry income in order to achieve the plan.

- This plan also assumes that the impact of strike action (if any) on the DHB's ability to deliver Elective volumes will not result in unfavourable revenue wash-ups.
- In the out-years, the depreciation impact for strategic projects such as FIRP is assumed to be cost neutral to the bottom-line, i.e. fully funded by the Ministry.

Overall, our funding increase from the 2019/20 forecast position to 2020/21 budget is $98.5M, with $55.2M increase in Ministry funding, $41.5M for IDFs and Inter-provider revenue and $1.7M in other income.

Expenditure Growth

Expenditure growth from the forecast for 2019/20 (excluding the Holidays Act impact on 2019/20) is $102.6M. The expenditure growth is driven by demographic growth pressure on services provided for the local, regional and national population, cost growth from MECA settlements and assumptions (including automatic step increases), staff FTE volume growth, cost of capital for investments, inflationary pressure and/or contractual pricing on clinical and non-clinical supplies and services. Key expenditure assumptions include the below.

- Settled MECAs have been budgeted at settlement levels and an average of 2% cost growth per annum in personnel costs (reflecting both employment contracts price factor and FTE volumes growth factor) for the outyears. This reflects the impact of employment agreement settlements and assumptions for unsettled MECAs expiring during the planning horizon.
- Clinical supplies cost growth reflects inflation factor in current contracts, estimation of price change on supplies, adjustments for known specific information within services and growth in volume of services provided by the DHB. HealthSource Procurement and Supply chain teams and other national entities continue to negotiate contract prices to realise more savings in this area although COVID-19 is expected to have an adverse impact on supply chain.
- Infrastructure cost growth (not including interest, depreciation and capital charge) in this category 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. Interest expense is based on asset leasing arrangements in place. Capital charge reflects the estimated Crown equity position at balance date at 6% capital charge and depreciation is based on the fixed asset register and capitalisations from the planned capital expenditure.
- Depreciation for approved strategic projects such as FIRP is assumed to be cost neutral per the approved business cases.
- No full asset revaluation was completed at June 2020, with a desk top assessment completed indicating no significant change in the value of land and improvements assets. As such, no capital charge or depreciation impacts have been included in the plans.
- The impact of capital charge on Crown equity for projects financed by the Crown is assumed to be cost neutral on the bottom-line, i.e. any additional capital charge impacting the bottom-line will be fully offset by additional revenue.
- Funder payments reflect historical cost growth patterns, demographic growth factor, inflationary factor, demand modelling (for demand-driven areas such as pharmaceuticals, primary health and aged residential care and for other areas), PHARMAC advised budgets for pharmaceuticals, contractual arrangements in place with providers and investments required in priority areas and specific initiatives funded expenditure.
- Out-years' expenditure growth is planned in line with the assumed future funding growth path, but still with a gap such that breakeven position cannot be achieved.
- No assumptions have been included for the ongoing impact of the Holidays Act non-compliance prior to this being remedied. The forecast result for 2019/20 includes a total provision of $279M (an increase in provision of $60.8M).
- Work is underway to develop a payroll system that will be able to correctly calculate the staff payments in line with the agreed principles in the Memorandum between DHBs, the Unions and MBIE.
- It is assumed that the Ministry will fund any payments to remediate the Holidays Act, including any future increases not assumed in the budgets.

Financial Risks

The key issues, risks and challenges for us during the planning horizon include the following:

Planning for a deficit and impact on cash and on-going financial sustainability

The planned deficits will impact the DHB's cash reserves and the ability to fund capital including baseline replacement if no deficit support is provided.

DHB expenditure is very sensitive to changes in the cost of settlement of MECAs. Settlements greater than the planned level with no offsetting funding will adversely impact the overall result. Any 1% change in personnel costs for Auckland DHB

equates to $12M (2020/21 planned cost). 2018/19 and 2019/20 has seen significant step increases in settled MECAs and this potentially creates expectations for future MECA settlements. This plan assumes that settlements will be within planned levels.

Sustainability of Services

Provision of sustainable services is dependent on the ability to live within our means. In the past, the deficit generated in the Provider Arm has been fully offset by surpluses in the Funder Arm but this is not sustainable hence the deficits projected. Easy to achieve savings are becoming more difficult to find and structural deficits need to be addressed by considering the revenue and cost structures of services provided. Any further cost pressures beyond planned levels will increase the risk of service sustainability.

InterDistrict Flows (IDFs)

The DHB revenue is sensitive to IDF wash-ups. If services delivered are below contract for washed up areas, the DHB's bottom-line could be impacted if there is insufficient capacity to absorb such shocks to the system.

Ability to invest in services

Currently, the DHB has very little, if any, ability to invest in areas that will reduce long-term demand for expensive hospital-based services. The DHB is constrained as these issues cannot be resolved by the DHB alone and input is required from the Ministry and other DHBs to resolve. The recent revision of population statistics resulting in the DHB being put in transitional funding further exacerbates the situation as the DHB will not receive demographic funding until PBFF parity is achieved.

Ability to invest in capital

Significant capital investment for remediation of aged facilities infrastructure, major upgrades and investment in new technology and clinical equipment replacement is required. Crown funding will be required to finance major redevelopment and upgrade projects, including funding or other mechanisms to alleviate the impact of large capital programmes on operating performance. We have assumed that flow on costs of Crown funded capital programmes are fully offset by additional funding.

Impact of Strikes, Measles Outbreak and COVID-19 future waves

As has been seen during 2018/19 and 2019/20, strikes, measles outbreaks and COVID-19 have had significant impacts on DHB financial performance. This plan assumes that any uncontrollable factors such as these will be fully offset by additional funding or no wash-ups on funding due to inability to deliver planned volumes.

Forecast Financial Statements

The Board of Directors of the Auckland DHB is responsible for issuing forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The forecast financial statements for the period 2020/21 to 2023/24 included in this Annual Plan are authorised by the Board of Directors on 12 July 2020.

The forecast financial statements were prepared to comply with the requirements of Section 149G of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose.

In line with the requirements of Section 149G of the Crown Entities Act 2004, we provide both the forecast financial statements of Auckland DHB and its subsidiaries (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities.

The Auckland DHB group consists of the parent, Auckland DHB and Auckland District Health Board Charitable Trust (controlled by Auckland DHB). Joint ventures are with healthAlliance N.Z. Limited and NZ Health Innovation Hub Management Limited. The associate company is Northern Regional Alliance Limited.

The tables below provide a summary of the forecast consolidated financial statements for the audited result for 2018/19, financial forecast for 2019/20 and, financial plans for years 2020/21 to 2023/24.

The forecast financial statements were prepared based on the key assumptions for financial forecasts and the significant accounting policies summarised in the Significant Accounting Policies outlined in this plan. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Statement of Comprehensive Revenue and Expenses – Group

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,582,373	1,687,379	1,742,995	1,809,961	1,872,292	1,979,908
Non-Government & Crown Agency Sourced	98,730	103,210	105,660	105,653	106,346	107,047
IDFs & Inter-DHB Sourced	660,368	701,179	745,417	771,233	792,847	831,389
TOTAL FUNDING	**2,341,471**	**2,491,768**	**2,594,073**	**2,686,847**	**2,771,486**	**2,918,344**
EXPENDITURE						
Personnel Costs	1,268,451	1,211,108	1,184,076	1,202,558	1,225,201	1,248,283
Outsourced Costs	141,366	155,064	153,967	156,257	159,196	164,420
Clinical Supplies Costs	302,474	308,527	326,698	337,222	345,381	354,793
Infrastructure & Non-Clinical Supplies Costs	214,417	216,629	224,496	233,336	253,672	292,452
Payments to Providers	546,962	599,022	635,023	638,138	665,311	729,608
IDF Outflows	100,167	103,143	114,856	119,335	122,724	128,787
TOTAL EXPENDITURE	**2,573,837**	**2,593,492**	**2,639,116**	**2,686,847**	**2,771,486**	**2,918,344**
Share of associate and joint venture	**399**	**(150)**	**-**	**-**	**-**	**-**
NET SURPLUS/(DEFICIT)	**(231,967)**	**(101,874)**	**(45,043)**	**-**	**-**	**-**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	83,512	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(DEFICIT)	**(148,455)**	**(101,874)**	**(45,043)**	**-**	**-**	**-**

The deficit of $101.9M forecast for 2019/20 is primarily due to the increase in the provision for the liability for non-compliance with the Holidays Act of $60.8M plus a $26.3M full year forecast unfunded COVID-19 impacts. The deficit planned for 2020/21 of $45M reflects partial implementation of funding for the price uplift and cost pressures not able to be absorbed within the funding advised. The deficit is sustained to future years. Auckland DHB is committed to operating in a financially sustainable manner and will continue to work on addressing the structural deficits in collaboration with central agencies and other DHBs as well as addressing any operational efficiencies to improve the bottom-line.

Statement of Comprehensive Revenue and Expenses – Parent

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,582,373	1,687,379	1,742,995	1,809,961	1,872,292	1,979,908
Non-Government & Crown Agency Sourced	97,389	102,390	104,832	104,816	105,502	106,194
IDFs & Inter-DHB Sourced	660,368	701,179	745,417	771,233	792,847	831,389
TOTAL FUNDING	**2,340,130**	**2,490,948**	**2,593,245**	**2,686,010**	**2,770,641**	**2,917,491**
EXPENDITURE						
Personnel Costs	1,267,898	1,210,526	1,183,489	1,201,964	1,224,602	1,247,678
Outsourced Costs	141,366	155,064	153,967	156,257	159,196	164,420
Clinical Supplies Costs	302,474	308,527	326,698	337,222	345,381	354,793
Infrastructure & Non-Clinical Supplies Costs	214,286	217,042	224,914	233,759	254,098	292,883
Payments to Providers	546,962	599,022	635,023	638,138	665,311	729,608
IDF Outflows	100,167	103,143	114,856	119,335	122,724	128,787
TOTAL EXPENDITURE	**2,573,153**	**2,593,323**	**2,638,947**	**2,686,676**	**2,771,313**	**2,918,170**
surplus/(deficit)	-	-	-	-	-	-
NET SURPLUS/(DEFICIT)	**(233,024)**	**(102,376)**	**(45,703)**	**(666)**	**(673)**	**(679)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	83,512	-	-	-	-	0
TOTAL COMPREHENSIVE INCOME/(DEFICIT)	**(149,511)**	**(102,376)**	**(45,703)**	**(666)**	**(673)**	**(679)**

Interest, Depreciation and Capital Charge

Included in infrastructure and non-clinical supplies costs are capital-related costs in the form of Interest, Depreciation and Capital Charge (IDCC).

Depreciation reflects the size and value of our asset base and rates of annual usage applied to the asset classes and the impact of new Capital expenditure investment in facilities and equipment over time and impact of asset revaluations and asset impairments.

Capital charge reflects the Crown's return on investment in the DHB and is impacted by upward movements in asset valuations, debt equity conversion noted above and the capital charge rate policy. These costs are summarised in the table below.

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
FINANCING COSTS						
Interest	410	562	1,184	1,206	1,229	1,260
Depreciation	52,306	55,495	60,632	68,508	74,505	89,540
Capital Charge	54,278	45,993	45,686	48,639	61,814	83,372
TOTAL FINANCING COSTS	**106,994**	**102,050**	**107,501**	**118,353**	**137,548**	**174,172**
% of Infrastructure & Non Clinical Supply Costs	**50%**	**47%**	**48%**	**51%**	**54%**	**60%**

To maintain overall 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 must be met within the funding available. Additional capital charge and depreciation for strategic projects are assumed to be cost neutral to the planned bottom-line.

Statement of Cashflows – Group

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
Cash receipts from MoH and patients	2,252,016	2,380,643	2,487,997	2,581,194	2,665,139	2,811,297
Other receipts	72,041	101,347	100,440	100,433	101,127	101,827
	2,324,057	**2,481,989**	**2,588,437**	**2,681,627**	**2,766,266**	**2,913,124**
Cash was applied to						
Cash paid to employees	(1,034,016)	(1,095,332)	(1,184,663)	(1,202,558)	(1,225,201)	(1,248,283)
Cash paid to suppliers	(1,188,362)	(1,279,571)	(1,349,593)	(1,339,673)	(1,409,966)	(1,497,149)
Net GST Paid	(14)	3,842	-	-	-	-
Payments for Capital Charge	(54,278)	(45,993)	(45,686)	(48,639)	(61,814)	(83,372)
	(2,276,669)	**(2,417,054)**	**(2,579,942)**	**(2,590,870)**	**(2,696,981)**	**(2,828,804)**
NET CASHFLOW FROM OPERATING ACTIVITIES	**47,388**	**64,935**	**8,495**	**90,757**	**69,285**	**84,320**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	5,867	4,159	5,220	5,220	5,220	5,220
Proceeds from Sale of property, plant & equipment	113	162	-	-	-	-
Decrease/(Increase) in Investments & restricted trust funds	(1,488)	13,034	-	-	-	-
	4,493	**17,354**	**5,220**	**5,220**	**5,220**	**5,220**
Cash was applied to						
Purchase of property, plant & equipment	(62,452)	(71,125)	(222,268)	(233,950)	(228,854)	(109,565)
Purchase of intangible assets	(3,202)	(838)	(13,456)	-	-	-
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(61,161)**	**(54,608)**	**(230,504)**	**(228,730)**	**(223,634)**	**(104,346)**
FINANCING ACTIVITIES						
Interest paid	(410)	(562)	(1,184)	(1,206)	(1,229)	(1,260)
Repayment of loans	4,983	4,983	4,983	4,983	4,983	4,983
Proceeds of borrowings	(97)	(3,084)	1,826	(7,712)	(7,712)	(7,712)
Proceeds from capital contributed/(repaid)	8,082	30,047	99,986	183,411	178,054	58,765
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**12,558**	**31,383**	**105,611**	**179,476**	**174,095**	**54,776**
NET CASH INFLOW/(OUTFLOW)	**(1,215)**	**41,710**	**(116,398)**	**41,502**	**19,746**	**34,751**
Cash & cash equivalents at the start of the year	**95,407**	**94,192**	**135,902**	**19,504**	**61,006**	**80,752**
Cash & cash equivalents at the end of the year	**94,192**	**135,902**	**19,505**	**61,006**	**80,752**	**115,503**

The operating cashflow deterioration in 2020/21 reflects the operating deficit planned and investment projects for baseline capital replacement and strategic projects. Baseline Capital is limited to around $50.8M of depreciation per year.

Statement of Cashflows – Parent

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
Cash receipts from MoH and patients	2,252,016	2,380,643	2,487,997	2,581,194	2,665,139	2,811,297
Other receipts	71,684	94,881	96,237	96,207	96,879	97,557
	2,323,700	**2,475,523**	**2,584,234**	**2,677,401**	**2,762,018**	**2,908,854**
Cash was applied to						
Cash paid to employees	(1,034,016)	(1,094,750)	(1,184,081)	(1,201,976)	(1,224,619)	(1,247,701)
Cash paid to suppliers	1,186,653)	(1,277,954)	(1,346,260)	(1,336,318)	(1,406,589)	(1,493,750)
Net GST Paid	166	3,731	-	-	-	-
Payments for Capital Charge	(54,278)	(45,993)	(45,686)	(48,639)	(61,814)	(83,372)
	(2,274,781)	(2,414,966)	(2,576,028)	(2,586,934)	(2,693,023)	(2,824,823)
NET CASHFLOW FROM OPERATING ACTIVITIES	**48,919**	**60,557**	**8,206**	**90,468**	**68,995**	**84,031**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	5,259	3,743	5,220	5,220	5,220	5,220
Proceeds from property, plant & equipment	113	162	-	-	-	-
Decrease/(Increase) in Investments & restricted trust funds	(2,411)	11,682	290	290	290	290
	2,962	**15,587**	**5,509**	**5,509**	**5,509**	**5,509**
Cash was applied to						
Purchase of property, plant & equipment	(62,452)	(71,125)	(222,268)	(233,950)	(228,854)	(109,565)
Purchase of intangible assets	(3,202)	(838)	(13,456)	-	-	-
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(62,692)**	**(56,375)**	**(230,215)**	**(228,441)**	**(223,345)**	**(104,056)**
FINANCING ACTIVITIES						
Interest paid	(410)	(562)	(1,184)	(1,206)	(1,229)	(1,260)
Repayment of loans	4,983	4,983	4,983	4,983	4,983	4,983
Proceeds of borrowings	(97)	(3,084)	1,826	(7,712)	(7,712)	(7,712)
contributed/(repaid)	8,082	30,047	99,986	183,411	178,054	58,765
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**12,558**	**31,383**	**105,611**	**179,476**	**174,095**	**54,776**
NET CASH INFLOW/(OUTFLOW)	**(1,215)**	**35,565**	**(116,398)**	**41,503**	**19,746**	**34,751**
Cash & cash equivalents at the start of the year	**95,407**	**94,192**	**129,757**	**13,359**	**54,862**	**74,607**
Cash & cash equivalents at the end of the year	**94,192**	**129,757**	**13,359**	**54,862**	**74,607**	**109,358**

Statement of Financial Position – Group

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	94,192	135,902	19,504	61,006	80,752	115,503
Investments	15,000	15,000	15,000	15,000	15,000	15,000
Trust/special funds	14,846	15,018	15,086	15,086	15,086	15,086
Restricted trust funds	1,308	1,376	1,308	1,308	1,308	1,308
Debtors & other receivables	86,868	98,937	98,937	98,937	98,937	98,937
Prepayments	996	5,729	6,635	5,931	5,227	4,522
Inventories	14,356	27,511	27,511	27,511	27,511	27,511
Total Current Assets	**227,566**	**299,472**	**184,181**	**224,779**	**243,820**	**277,867**
Non-current assets						
Investments	15,000	-	-	-	-	-
Trust/special funds	17,200	15,970	15,970	15,970	15,970	15,970
Property, Plant and Equipment	1,117,387	1,132,720	1,288,234	1,442,272	1,600,190	1,565,919
Intangible Assets	8,524	7,971	18,645	2,179	(2,822)	(8,832)
Investment in joint ventures & associates	71,003	75,057	75,057	75,057	75,057	75,057
Total Non-Current Assets	**1,229,114**	**1,231,718**	**1,397,905**	**1,535,478**	**1,688,395**	**1,648,114**
TOTAL ASSETS	**1,456,680**	**1,531,190**	**1,582,086**	**1,760,257**	**1,932,215**	**1,925,981**
LIABILITIES						
Current liabilities						
Payables and deferred revenue	166,338	195,760	184,981	182,912	179,795	117,773
Employee benefits	409,422	505,323	505,323	505,323	505,323	505,323
Borrowings	1,176	1,925	1,925	1,828	1,828	1,828
Restricted trust funds	1,308	1,384	1,308	1,308	1,308	1,308
Total Current Liabilities	**578,244**	**704,392**	**693,536**	**691,370**	**688,253**	**626,231**
Non-current liabilities						
Employee Benefits	69,895	88,931	88,931	88,931	88,931	88,931
Borrowings	8,983	10,136	16,945	13,869	10,892	7,914
Total Non-Current Liabilities	**78,878**	**99,067**	**105,876**	**102,800**	**99,823**	**96,845**
TOTAL LIABILITIES	**657,122**	**803,459**	**799,412**	**794,170**	**788,076**	**723,076**
EQUITY						
Contributed Capital	889,380	919,426	1,019,413	1,202,824	1,380,878	1,439,643
Accumulated surplus/(deficit)	(717,130)	(819,655)	(865,357)	(866,022)	(866,694)	(867,373)
Property revaluation reserve	599,151	599,151	599,151	599,151	599,151	599,151
Trust/special funds	28,157	28,809	29,468	30,133	30,804	31,483
TOTAL EQUITY	**799,558**	**727,731**	**782,675**	**966,086**	**1,144,139**	**1,202,905**
NET ASSETS	**799,558**	**727,731**	**782,675**	**966,086**	**1,144,139**	**1,202,905**

The movement in Crown equity balances reflects the increase in equity for Crown funded significant investments under implementation such as FIRP and BFTF. However, this is also net of reductions due to the sustained deficits.

Statement of Financial Position – Parent

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	94,192	129,757	13,359	54,861	74,607	109,358
Investments	15,000	15,000	15,000	15,000	15,000	15,000
Trust/special funds	-	-	-	-	-	-
Restricted trust funds	1,308	1,376	1,308	1,308	1,308	1,308
Debtors & other receivables	88,191	101,100	101,150	101,201	101,253	101,305
Prepayments	996	5,729	6,835	5,931	5,227	4,522
Inventories	14,356	27,511	27,511	27,511	27,511	27,511
Total Current Assets	**214,043**	**280,472**	**165,164**	**205,813**	**224,906**	**259,004**
Non-current assets						
Investments	15,000	-	-	-	-	-
Trust/special funds	-	-	-	-	-	-
Property, plant & equipment	1,116,448	1,131,781	1,287,295	1,441,333	1,599,251	1,564,980
Intangible Assets	8,524	7,971	18,645	2,179	(2,822)	(8,832)
Investment in joint ventures & associates	70,066	74,539	74,539	74,539	74,539	74,539
Total Non-Current Assets	**1,210,038**	**1,214,291**	**1,380,478**	**1,518,051**	**1,670,968**	**1,630,687**
TOTAL ASSETS	**1,424,081**	**1,494,763**	**1,545,642**	**1,723,864**	**1,895,874**	**1,889,692**
LIABILITIES						
Current liabilities						
Payables & deferred revenue	162,691	188,789	178,654	177,302	174,908	113,617
Employee benefits	409,396	505,296	505,296	505,296	505,296	505,296
Borrowings	1,176	1,925	1,925	1,828	1,828	1,828
Restricted trust funds	1,308	1,384	1,308	1,308	1,308	1,308
Total Current Liabilities	574,571	**697,394**	**687,183**	**685,734**	**683,340**	**622,049**
Non-current liabilities						
Employee Benefits	69,895	88,931	88,931	88,931	88,931	88,931
Borrowings	8,983	10,136	16,945	13,869	10,892	7,914
Total Non-Current Liabilities	78,878	**99,067**	**105,876**	**102,800**	**99,823**	**96,845**
TOTAL LIABILITIES	**653,450**	**796,461**	**793,059**	**788,534**	**783,163**	**718,894**
EQUITY						
Contributed Capital	889,380	919,426	1,019,413	1,202,824	1,380,878	1,439,643
Accumulated surplus/(deficit)	(717,901)	(820,276)	(865,981)	(866,647)	(867,319)	(867,997)
Property revaluation reserve	599,151	599,151	599,151	599,151	599,151	599,151
Trust/special funds	-	-	-	-	-	-
TOTAL EQUITY	**770,631**	**698,302**	**752,584**	**935,329**	**1,112,711**	**1,170,797**
NET ASSETS	**770,631**	**698,302**	**752,584**	**935,329**	**1,112,711**	**1,170,797**

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 Te Tiriti o Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of Changes in Net Assets/Equity – Group

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
BALANCE AT 1 JULY	**939,932**	799,558	727,731	782,675	966,086	1,144,139
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	(231,967)	(101,874)	(45,043)	-	-	-
Gains/(Losses) on Property Revaluations	83,512	-	-	-	-	-
Other movements	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**791,477**	**697,684**	**682,688**	**782,675**	**966,086**	**1,144,139**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	8,082	30,047	99,986	183,411	178,054	58,765
BALANCE AT 30 JUNE	**799,558**	**727,731**	**782,675**	**966,086**	**1,144,139**	**1,202,904**

The shareholder's equity position is impacted by the planned deficits and Crown Equity injections for capital projects.

Statement of Changes in Net Assets/Equity – Parent

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
BALANCE AT 1 JULY	**912,061**	**770,631**	**698,302**	**752,584**	**935,329**	**1,112,711**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	(149,511)	(102,376)	(45,703)	(666)	(673)	(679)
Gains/(Losses) on Property Revaluations	-	-	-	-	-	-
Other movements	-	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(149,511)**	**(102,376)**	**(45,703)**	**(666)**	**(673)**	**(679)**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	8,082	30,047	99,986	183,411	178,054	58,765
BALANCE AT 30 JUNE	**770,631**	**698,302**	**752,584**	**935,329**	**1,112,711**	**1,170,798**

Additional Information

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

Funder Arm Financial Performance

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
REVENUE						
Government & Crown Agency Sourced	1,460,776	1,563,476	1,612,667	1,675,561	1,723,147	1,808,271
Non-Government & Crown Agency Sourced	15,266	11,409	10,272	10,375	10,478	10,583
IDFs & Inter-DHB Sourced	643,399	686,267	727,176	755,536	776,993	815,376
TOTAL REVENUE	**2,119,440**	**2,261,152**	**2,350,115**	**2,441,472**	**2,510,619**	**2,634,230**
EXPENDITURE						
Payment to Provider	1,390,833	1,478,591	1,565,578	1,642,917	1,693,585	1,745,815
Payment to Governance	14,730	15,323	15,758	16,073	16,395	16,723
Total Payments to Internal Provider	**1,405,563**	**1,493,914**	**1,581,336**	**1,658,991**	**1,709,980**	**1,762,538**
NGO Expenditure						
Personal Health	339,214	354,490	384,762	380,849	399,635	447,489
Mental Health	37,601	42,896	53,187	53,461	54,647	59,957
DSS	167,284	177,108	192,821	199,432	206,478	217,364
Public Health	1,416	22,961	2,687	2,778	2,876	3,029
Māori Health	1,447	1,568	1,567	1,617	1,675	1,769
Total Payments to NGO providers	**546,962**	**599,022**	**635,023**	**638,138**	**665,311**	**729,608**
IDF Outflows	100,167	103,143	114,856	119,335	122,724	128,787
Total Payments to External Providers	**647,129**	**702,165**	**749,879**	**757,473**	**788,036**	**858,395**
TOTAL EXPENDITURE	**2,052,692**	**2,196,079**	**2,331,215**	**2,416,464**	**2,498,015**	**2,620,933**
SURPLUS/(DEFICIT)	**66,748**	**65,073**	**18,900**	**25,008**	**12,603**	**13,297**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME	**66,748**	**65,073**	**18,900**	**25,008**	**12,603**	**13,297**

The Funder is planning a surplus in each of the planning years, which partially offsets planned deficits in the Provider arm but is not sufficient to achieve a breakeven result. The DHB's Production Plan Template will be submitted to the Ministry, which summarises the service volumes planned for 2020/21.

The joint Funder collaboration arrangements between Auckland and Waitematā DHBs remain in place, with Funding Administration staff employed by Waitematā DHB on behalf of the two DHBs. Funder arm financial plans and performance for Auckland DHB continue to be reported through the Auckland DHB financial accounts and statement of service performance.

Additional funding resulting in the overall DHB surplus is accounted for in the DHB funder arm. The planned Funder result assumes that funding for this is sustained in future years.

Provider Arm Financial Performance

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
INCOME						
MoH Base via Funder	1,406,423	1,493,504	1,583,820	1,658,615	1,709,439	1,761,828
MoH Direct	61,720	63,573	73,994	77,502	91,678	113,596
Other	143,741	151,281	151,722	152,175	153,334	154,505
TOTAL INCOME	**1,611,883**	**1,708,357**	**1,809,536**	**1,888,292**	**1,954,452**	**2,029,929**
EXPENDITURE						
Personnel	1,264,255	1,206,478	1,179,634	1,198,067	1,220,659	1,243,691
Outsourced Services	129,627	139,651	137,951	139,530	142,156	146,797
Clinical Supplies	302,104	308,288	326,540	337,062	345,218	354,626
Infrastructure & non clinical supplies	212,844	214,824	219,636	229,193	249,450	288,124
Other	5,434	7,825	9,656	7,950	8,101	8,303
TOTAL EXPENDITURE	**1,914,265**	**1,877,067**	**1,873,418**	**1,911,801**	**1,965,584**	**2,041,542**
SURPLUS/(DEFICIT)	**(302,382)**	**(168,709)**	**(63,882)**	**(23,509)**	**(11,132)**	**(11,613)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	83,512	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(218,870)**	**(168,709)**	**(63,882)**	**(23,509)**	**(11,132)**	**(11,613)**

The Provider Arm financial plan is for a deficit in each of the planning years. This is partially offset by the surpluses in the Funder. Funding issues described in the Financial Sustainability and Financial Planning Setting sections mainly relate to the Provider arm. As a provider of last resort, Auckland DHB accepts referrals from other DHBs for national services and for IDF services, irrespective of the funding allowed in the Funding Envelope. Funding issues for IDFs and some of the national services have been signalled to other DHBs and the Ministry. These issues need to be resolved at national and regional level as they are systemic. The DHB will continue working on the internal issues to improve productivity, improve processes and contain cost growth within controllable areas.

Governance and Funding Administration Arm Financial Performance

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
Revenue from Funder Arm	16,109	15,323	15,758	16,073	16,395	16,723
Revenue Other	-	700	-	-	-	-
TOTAL INCOME	**16,109**	**16,023**	**15,758**	**16,073**	**16,395**	**16,723**
EXPENDITURE	**12,442**	**14,261**	**15,819**	**17,572**	**17,866**	**18,407**
SURPLUS/(DEFICIT)	**3,667**	**1,762**	**(61)**	**(1,499)**	**(1,472)**	**(1,684)**
TOTAL COMPREHENSIVE INCOME	**3,667**	**1,762**	**(61)**	**(1,499)**	**(1,472)**	**(1,684)**

The Governance and Funding Administration arm continues to perform within the funding allocated.

Capital Expenditure

The Capital Intentions for the DHB have been included in the Annual Plan financial templates and are summarised in the table below. The capital plan reflects the level of capital able to be funded from internally generated cash (mainly depreciation free cashflow) as well as strategic projects that are funded by Crown Equity. Ongoing capital investment is required to meet growth in services, compliance-related investments and investments in information technology. The Regional LTIP developed informs the main investment requirements prioritised for the region. Auckland DHB has three strategic projects included in the regional LTIP that are being progressed or in development, that is; FIRP, HARP and BFTF. A brief overview of these has been provided in this plan. Strategic projects that have not yet been approved are not included in this plan.

	2018/19 Audited $'000	2019/20 Forecast $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000
FINANCING SOURCES						
Free cashflow from depreciation	52,306	55,495	60,632	68,508	74,505	89,540
External Crown Funding	8,082	30,047	99,986	183,411	178,054	58,765
Private Funding – Finance leases	4,886	1,899	6,809	(2,729)	(2,729)	(2,729)
Donations	-	-	-	-	-	-
Cash Reserves	(1,028)	(15,479)	68,297	(15,239)	(20,975)	(36,011)
TOTAL FINANCING	**64,246**	**71,962**	**235,724**	**233,950**	**228,854**	**109,565**
BASELINE CAPITAL EXPENDITURE						
Land	1,000	-	-	-	-	-
Buildings and Plant	15,692	12,554	52,617	18,000	18,000	18,000
Clinical Equipment	21,333	15,646	34,279	24,000	24,000	24,000
Other Equipment	1,496	349	2,942	600	600	600
Information Technology (Hardware)	323	1,323	-	2,000	2,000	2,000
Intangible Assets (Software)	477	(947)	13,456	5,200	5,200	5,200
Motor Vehicles	779	736	823	1,000	1,000	1,000
TOTAL BASELINE CAPITAL PAYMENTS	**41,100**	**29,661**	**104,117**	**50,800**	**50,800**	**50,800**
STRATEGIC INVESTMENTS						
Land	-	-	-	-	-	-
Buildings & Plant	21,828	39,987	121,746	183,150	178,054	58,765
Clinical Equipment	-	530	8,653	-	-	-
Other Equipment	-	-	-	-	-	-
Information Technology (Hardware)	-	-	-	-	-	-
Intangible Assets (Software)	1,318	1,785	1,208	-	-	-
Motor Vehicles	-	-	-	-	-	-
TOTAL STRATEGIC CAPITAL EXPENDITURE	**23,146**	**42,301**	**131,607**	**183,150**	**178,054**	**58,765**
TOTAL CAPITAL PAYMENTS	**64,246**	**71,962**	**235,724**	**233,950**	**228,854**	**109,565**

Banking Facilities and Covenants

Term Debt Facilities and Covenants

Auckland DHB does not have any more term debt.

Shared Commercial Banking Services

Auckland DHB continues to participate in the DHBs' shared commercial banking arrangements with BNZ, other DHBs and New Zealand Health Partnership Limited (NZHPL). Under these arrangements, DHBs are not required to maintain separate overdraft or stand by facilities for working capital.

Statement of Accounting Policies

The forecast financial statements have been prepared based on the significant accounting policies, which are expected to be used in the future for reporting historical financial statements. The significant accounting policies used in the preparation of these forecast financial statements included in this Annual Plan are summarised below. A full description of accounting policies used by Auckland DHB for financial reporting is provided in the Annual Reports that are published on the Auckland DHB website: www.adhb.govt.nz/publications.

Reporting entity

The Auckland District Health Board (Auckland DHB) is a Crown entity as defined by the Crown Entities Act (2004) and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown. Auckland DHB has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes. 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 forecast consolidated financial statements of Auckland DHB comprise Auckland DHB and its subsidiary (together referred to as 'Group') and Auckland DHB's interest in associates and jointly controlled entities. The Auckland DHB group consists of the parent, Auckland DHB, Auckland District Health Board Charitable Trust (controlled by Auckland DHB) and Auckland Health Foundation. Joint ventures are healthAlliance N.Z. Limited (39.88%) and New Zealand Health Partnership Limited (18.18%). Associate is Northern Regional Alliance Limited (33.3%). The DHB's subsidiaries, associate and joint ventures are incorporated and domiciled in New Zealand.

Basis of preparation

The forecast financial statements were prepared on a going concern basis, and the accounting policies were applied consistently throughout the period.

Going concern

The forecast financial statements of the DHB have been prepared on a going concern basis.

Statement of compliance

The forecast financial statements of the DHB were prepared in accordance with the requirements of the New Zealand Public Health and Disability Act (2000) and the Crown Entities Act (2004), which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). These forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*. These forecast financial statements comply with Public Sector PBE accounting standards. The forecast financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Presentation currency and rounding

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

Forecast information

In preparation of the forecast financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results. The forecast financial statements for the year ended 30 June 2020 incorporate the result currently being audited.

Standards issued that are not yet effective and not early adopted

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Auckland DHB does not intend to early adopt the amendment.

PBE IPSAS 34-38

PBE IPSAS 34-38 replace the existing standards for interests in other entities (PBE IPSAS 6-8). These new standards are effective for annual periods beginning on or after 1 January 2019. Auckland DHB will apply these new standards in preparing the 30 June 2020 financial statements. No effect is expected as a result of this change.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Auckland DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS.

Summary of Significant Accounting Policies

Basis of consolidation

Subsidiaries

Auckland DHB consolidates in the group financial statements all entities where the DHB has the capacity to control their financing and operating policies to obtain benefits from the activities of the subsidiary. This power exists where the DHB controls the majority voting power on the governing body or where financing and operating policies have been irreversibly predetermined by the DHB or where the determination of such policies is unable to materially affect the level of potential ownership benefits that arise from the activities of the subsidiary.

Auckland DHB will recognise goodwill where there is an excess of the consideration transferred over the net identifiable assets acquired and liabilities assumed. This difference reflects the goodwill to be recognised by the DHB. If the consideration transferred is lower than the net fair value of the DHBs interest in the identifiable assets acquired and liabilities assumed, the difference will be recognised immediately in the surplus or deficit.

The investment in subsidiaries is carried at cost in Auckland DHB's parent entity forecast financial statements. The Auckland District Health Board Charitable Trust and Auckland Health Foundation are controlled by the DHB.

Foreign currency transactions

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

Revenue

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

Revenue items	Explanation
MoH revenue	The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within Auckland DHB district. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.
MoH contract revenue	The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future years is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.
ACC contract revenue	ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.
Revenue from other DHBs	Inter district patient inflow revenue occurs when a patient treated within the Auckland DHB region is domiciled outside of Auckland. The Ministry of Health credits Auckland DHB with a monthly amount based on estimated patient treatment for non-Auckland residents within Auckland. An annual wash up occurs (in agreed areas) at year end to reflect the actual non Auckland patients treated at Auckland DHB.
Donated services	Certain operations of the DHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB.
Grants revenue	Revenue from grants includes grants given by other charitable organisations, government organisations or their affiliates. Income from grants is recognised when the funds transferred meet the definition of an asset as well as the recognition criteria of an asset. Grants are recognised when they become receivable unless there is an obligation in substance to return the funds if conditions of the grant are not met. If there is such an obligation, the grants are initially recorded as income received in advance and recognised as revenue when conditions of the grant are satisfied.
Research grants	For an exchange research contract, revenue is recognised on a percentage completion basis. The percentage of completion is measured by reference to the actual research expenditure incurred as a proportion to total expenditure expected to be incurred. For a non-exchange research contract, the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to complete research to the satisfaction of the funder to retain funding or return unspent funds. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the

Revenue items	Explanation
	requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as contract monitoring mechanisms of the funder and the past practice of the funder.
Interest revenue	Interest revenue is recognised using the effective interest method.
Rental revenue	Rental revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.
Provision of services	Revenue derived from the provision of other services to third parties is recognised in proportion to the stage of completion at balance date, based on the actual service provided as a percentage of the total services to be provided.
Donations and bequests	Donated and Bequeathed financial assets are recognised as revenue, unless there are substantive use or return conditions. A liability is recorded if there are substantive use or return conditions and the liability released to revenue as the conditions are met. For example, as the funds are spent for the nominated purpose.

Personnel costs

Salaries and wages
Salaries and wages are recognised as an expense as employees provide services.

Superannuation schemes

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

Defined benefit schemes
The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme. Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme.

Capital charge

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

Other expenses

Borrowing costs

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

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Cash and cash equivalents

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

Investments

Bank term deposits
Investments in bank term deposits are initially measured at the amount invested. Interest is subsequently accrued and added to the investment balance. A loss allowance for expected credit losses is recognised if the estimated loss allowance is not trivial.

Trust/Special fund assets

The assets are funds held by the Auckland DHB Charitable Trust, and comprise donated and research funds. The use of the funds must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds are recognised in the surplus or deficit, and is transferred from/to trust funds in equity.

Receivables

Short term receivables are recorded at the amount due, less an allowance for credit losses.

Auckland DHB applies the simplified expected credit loss model of recognising lifetime expected credit losses for receivables. In measuring expected credit losses, short-term receivables have been assessed on a collective basis as they possess shared credit risk characteristics. They have been grouped based on the days past due. Short-term receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include the debtor being in liquidation.

Inventories

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

transactions are measured at fair value at the date of acquisition. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell. Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes: land; buildings (including fit outs and underground infrastructure); leasehold Improvements; and plant, equipment and vehicles.

Owned Assets

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses. The cost of property, plant and equipment acquired in a business combination is their fair value at the date of acquisition.

Revaluations

Land and buildings and underground infrastructure are re-valued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of re-valued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be re-valued. Land and building revaluation movements are accounted for on a class-of-asset basis.

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

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost less impairment, and is not depreciated. In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at fair value as at the date of acquisition.

Disposals

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

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

- Buildings (including components) 4–137 years 0.73–25%
- Plant, equipment and vehicles 5–20 years 5.00–20%
- Leasehold improvements 5 years 20%.

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Business combination and goodwill

Business combinations are accounted for using the acquisition method. The acquisition method involves recognising at acquisition date,

separately from goodwill, the identifiable assets acquired and the liabilities assumed. The identifiable assets acquired and the liabilities assumed are measured at their acquisition date fair values.

When the Group acquires a business, it assesses the financial assets and liabilities assumed for appropriate classification and designation in accordance with the contractual terms, economic conditions, the Group's operating or accounting policies and other pertinent conditions as at the acquisition date.

Goodwill is initially measured at cost, being the excess of the aggregate of the consideration transferred and the amount recognised for non-controlling interests over the net identifiable assets acquired and liabilities assumed. After initial recognition, goodwill is measured at cost less any accumulated impairment losses. Goodwill is tested annually for impairment.

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

The useful lives and associated amortisation rates of major classes of intangible assets were estimated as:

- Acquired software 3 to 5 years (20–33%)
- Internally developed software 3 to 5 years (20–33%)
- Goodwill 29 months (42%).

Indefinite life intangible assets are not amortised, and are tested annually for impairment.

Impairment of property, plant, and equipment and intangible assets

Auckland DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate commercial return.

Non-cash generating assets
Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use. Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information. If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit. For assets not carried at a re-valued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Investments in joint venture and associates

Joint Ventures
A joint venture is a binding arrangement whereby two or more parties are committed to undertake an activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. The consolidated forecast financial statements include Auckland DHB's joint interest in the jointly controlled entities, using the equity method, from the date that joint control commences until the date that joint control ceases. Investments in jointly controlled entities are carried at cost in the DHB's parent entity financial statements.

Associates
An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. 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

Payables

Short-term payables are recorded at their face value.

Employee entitlements

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

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences. A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

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

- likely future entitlements accruing to staff based on years of service; years to entitlement;

- likelihood that staff will reach the point of entitlement and contractual entitlement information;
- present value of the estimated future cash flows.

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

Provisions

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

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and is included in 'finance costs'.

Restructuring
A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either been announced publicly to those affected, or has already started being implemented.

Legal and onerous contracts
A provision for onerous contracts is recognised when the expected benefits or service potential to be derived from a contract are lower than the unavoidable cost of meeting the obligations under the contract. Legal provisions are recognised for contractual disputes, internal investigation and tax audit advice.

ACC Accredited Employers Programme
The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC. The liability for the ACC Accredited Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Borrowings

Borrowings on commercial terms are initially recognised at the amount borrowed plus transaction costs. Interest due on the borrowings is subsequently accrued and added to the borrowing balance. Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Equity
Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components: contributed capital; accumulated surplus/(deficit); reserves-property revaluation and cashflow hedge and trust funds.

Property Revaluation Reserves
The reserves related to the revaluation of land and buildings to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to the DHB. The restrictions generally specify how the donations and bequests are required to be spent in providing specified deliverables of the bequest. The receipt of, and investment revenue earned on, trust funds is recognised as revenue and then transferred to the trust funds' reserve from accumulated surpluses/(deficits). Application of trust funds on the specified purpose is recognised as an expense, with an equivalent amount transferred to \accumulated surpluses/(deficits) from the trust funds' reserve.

Goods and services tax

All items in the forecast financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the Statement of Financial Position. The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Cost allocation

The DHB has determined the cost of outputs using the cost allocation system outlined below. Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output. Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation.

Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output. There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these forecast financial statements, the DHB has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Estimating the fair value of land and building revaluations

The most recent valuation of land was performed by an independent registered valuer, Evan Gamby (M PROP STUD Distn, DIP UV, FNZIV (Life), LPINZ, FRICS) of Telfer Young (Auckland) Limited. The valuation is effective as at 30 June 2017. The next full revaluation of land and buildings will be completed as at 30 June 2019.

Land

Land is valued at fair value using market-based evidence based on its highest and best use with reference to comparable land values. All titles other than those relating to 50 Grafton Road are noted by certificate 9918215.1 as being subject to Section 148 of Nga Mana Whenua o Tamaki Makaurau Collective Redress Act (2014) ("The Act") that the land is RFR land as defined in section 118 and is subject to Subpart 1 of Part 4 of The Act (which restricts disposal, including leasing of the land).

Values have been adjusted to reflect the imposition of Section 148 of The Act. Restrictions on Auckland DHB's ability to sell land would normally not impair the value of the land because Auckland DHB has operational use of the land for the foreseeable future and will substantially receive the full benefits of outright ownership.

Buildings

Buildings, fit out and infrastructures were last re-valued on 30 June 2016 by Telfer Young (Auckland) Ltd.

Specialised buildings are valued at fair value using depreciated replacement cost because no reliable market data is available for such buildings.

Depreciated replacement cost is determined using a number of significant assumptions. Significant assumptions include:

- The replacement asset is based on the reproduction cost of the specific assets with adjustments where appropriate for optimisation due to over-design or surplus capacity.
- The replacement cost is derived from recent construction contracts of similar assets and Property Institute of New Zealand cost information.
- For Auckland DHB's earthquake-prone buildings that are expected to be strengthened, the estimated earthquake-strengthening costs have been deducted off the depreciated replacement cost in estimating fair value.
- The remaining useful life of assets is estimated, after considering factors such as the condition of the asset, DHB's future maintenance and replacement plans and experience with similar buildings.
- Straight-line depreciation has been applied in determining the depreciated replacement cost value of the asset.
- The estimated cost of asbestos remediation in Auckland DHB's buildings has been deducted off the depreciated replacement cost in estimating value.

Non-specialised buildings (for example, residential buildings) are valued at fair value using market-based evidence. The following market rents and capitalisation rates were used in the 30 June 2016 valuation:

- Land market values range from $3,000 to $4,000 per square metre depending on location
- Market rents range from $2,414 to $4,953 per square metre
- Capitalisation rates are market-based rates of return and range from 6.52% to 8.23%.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by the DHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the Statement of Financial Position. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes;

- review of second-hand market prices for similar assets;
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Measuring Retirement Gratuities and Long Service Leave
The present value of long service leave and retirement gratuities obligations depend on a number of factors that are determined on an actuarial basis. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any changes in these assumptions will affect the carrying amount of the liability. Expected future payments are discounted using forward discount rates derived from the yield curve of New Zealand government bonds. The discount rates used have maturities that match, as closely as possible, the estimated future cash outflows. The salary inflation factor has been determined after considering historical salary inflation patterns and future movements. The discount rates used are those advised by the Treasury. The salary inflation factor is the DHB's best estimate forecast of salary increments. The retirement age has changed from 65 to 68 with 20% probability of early retirement at each age from 65 to 67.

Continuing Medical Education Leave
The continuing medical education leave liability assumes the utilisation of the annual entitlement based on recent experience.

Salaries and wages accrual
Salaries and wages accrual is calculated as the expected cost to be paid within the next 12 months relating to the financial year being reported, including allowance for known salary and wage movements.

Measuring liability to comply with the Holidays Act 2003
Holidays Act 2003 ('the Act'). Work has been ongoing since 2016 on behalf of 20 District Health Boards (DHBs) and the New Zealand Blood Service (NZBS), with the Council of Trade Unions (CTU), health sector unions and Ministry of Business Innovation and Employment (MBIE) Labour Inspectorate, for an agreed and national approach to identify, rectify and remediate any Holidays Act non-compliance by DHBs. DHBs have agreed to a Memorandum of Understanding (MOU), which contains a method for determination of individual employee earnings, for calculation of liability for any historical non-compliance. For employers such as the DHBs that have workforces that include differential occupational groups with complex entitlements, non-standard hours, allowances and/or overtime, the process of assessing non-compliance with the Act and determining any additional payment is time consuming and complicated. The remediation project associated with the MOU is a significant undertaking and work to assess all non-compliance will continue through the 2019/20 financial year. The review process agreed as part of the MOU will roll-out in tranches to the DHBs and NZBS, expected to be over 18 months although DHB readiness and availability of resources (internal and external to the DHB) may determine when a DHB can commence the process. The final outcome of the remediation project and timeline addressing any non-compliance will not be determined until this work is completed.

Notwithstanding, in preparing the forecasted financial statements, Auckland DHB recognises it has an obligation to address any historical non-compliance under the MOU and has made estimates and assumptions to determine a potential liability based on its own review of payroll processes which identified instances of non-compliance with the Act and the requirements of the MOU. This was based on selecting a sample of current and former employees; making a number of early assumptions; calculating an indicative liability for those current and former employees; and extrapolating the result. A provision for non-compliance with the Holidays Act has been made in the forecasted financial statements based on best estimate. However, until the project has progressed further, there remain substantial uncertainties. The estimates and assumptions may differ to the subsequent actual results as further work is completed and may result in further adjustment to the carrying amount of the provision liabilities within the next financial year.

Classification of Leases
Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Identifying Agency Relationship
Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sales of goods or the rendering of services. The judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

Some individual DHBs have entered into contracts for services with providers on behalf of themselves (contracting DHB) and other DHBs (recipient DHB). The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. Therefore, the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

APPENDIX D: 2020/21 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2020
2021

FINANCIAL YEAR

***Tawhiti rawa tō tātou haerenga te kore haere tonu, maha rawa wā tātou mahi te kore mahi tonu*.**

We have come too far to not go further and we have done too much to not do more.

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed a 2020/21 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system.

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a further consolidation of the 2018/19 plan. The COVID-19 pandemic has had a significant impact on the delivery of the SLM programme. Primary care capacity to engage with a broad plan has been reduced. The 2020/21 plan has been through a prioritisation process to focus on post-pandemic priorities. Some activities have been removed from the current plan and will be reintroduced in subsequent plans.

Some activities have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. Activities have been included where they can be expected to contribute to milestone measures over a three year time frame. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement.

New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities. Examples of this include alcohol harm reduction and smoking cessation rates. An extensive stocktake of activity against the 2018/19 plan, across primary and secondary care allowed stakeholders to contribute to the prioritisation of activities in the current plan.

The Alliances are firmly committed to including additional well-aligned contributory measures over a three year timeframe, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

The district health boards (DHBs) included in this improvement plan are:

- Auckland DHB;
- Waitematā DHB, and
- Counties Manukau DHB.

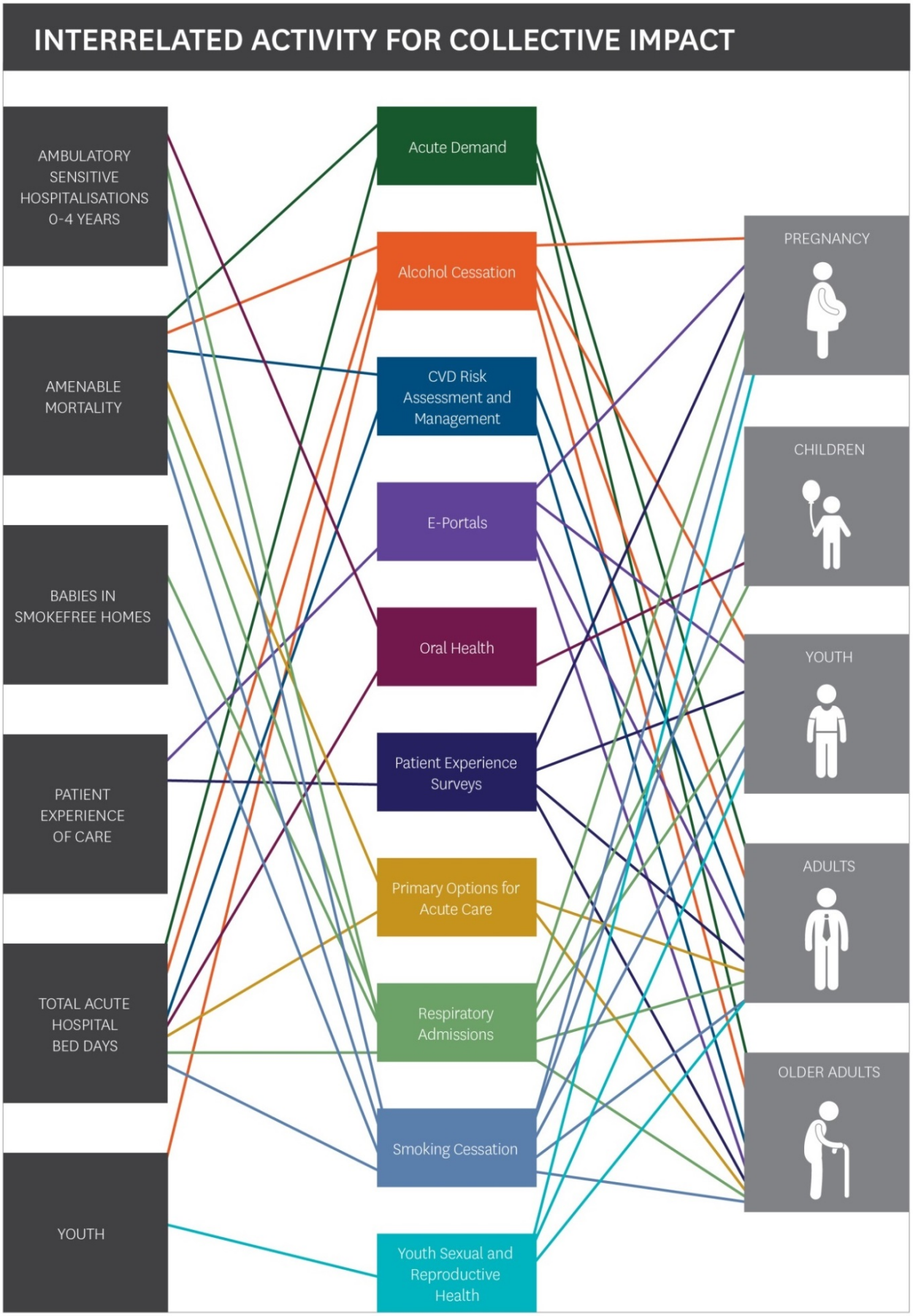
The primary health organisations (PHOs) included in this improvement plan are:

- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health (PHO) Limited;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the relationship between milestones and key activities chosen for the Metro Auckland System Level Measures, and the stage of life they represent. The current plan will maintain this approach of supporting activities and contributory measures that will have impact on multiple milestones.

The plan continues to promote a prevention approach and a strong focus on improving equity of outcome for Māori and other populations with high health need across the greater Auckland region.

INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



PURPOSE

This document outlines how the 2020/21 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, implementation planning is developed annually to sit under this document to provide a higher level of detail.

BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand's health system over 10 years to 2026, to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is 'value and high performance' 'te whāinga hua me te tika o ngā mahi'. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a suite of SLMs that provide a system-wide view of performance. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following six SLMs:

- ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds
- total acute hospital bed days per capita
- patient experience of care
- amenable mortality rates
- youth access to and utilisation of youth-appropriate health services, and
- babies living in smokefree homes.

Each SLM, has an improvement milestone to be achieved in 2020/21. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs. A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones. Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enable the alliance to measure local progress against the SLM activities. Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

In 2016, the Counties Manukau Health and Auckland Waitematā Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2020/21, SLMs continue to be business-as-usual. There is a focus on risk factors for respiratory infections including smoking, vaccination for influenza and pertussis. There is also priority given to effective use of Primary options for Acute Care (POAC) to prevent unnecessary use of hospitals and greater use of primary care patient portals to improve efficiency of contactless primary care where appropriate. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily with the Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The Implementation Groups stopped meeting during the pandemic but will again meet regularly during 2020/21 to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.

The work of the Implementation Group is guided by an Implementation Plan which sits under this plan and contains considerably more detail on activities and timeframes, and how a quality improvement approach will be taken for each area. The distinction between this high level plan and an implementation plan is necessary in a relatively complex environment of seven PHOs spanning three DHBs. We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other systems partners.

Data sharing between primary and secondary care is developing under the Metro Auckland Data Sharing Framework. This allows data matching with primary care and non-primary care data sources, more consistent reporting, establishment of baseline performance across DHBs and PHOs and drives quality improvement facilitated by the Implementation Group.

Reporting processes, both at a local and regional level have been embedded and DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the Implementation Group.

Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor was tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan was shared with the DHB Māori, Pacific and Asian health gain teams and their feedback was incorporated. Consultation with other relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan was designed to align with DHB Māori Health Plans. The 2020/21 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity.

Regional Working

As in previous years, a single improvement plan has been developed in 2019/20 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

2020/21 Priorities for System Level Measures

The 2020/21 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the 'interrelated activity for collective impact' diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation for the 2019/20 plan. The results of the stocktake were discussed with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan.

The COVID-19 pandemic has put the health system and particularly primary care under pressure. This year's plan has been influenced by this event and has a focus on preventing respiratory illness by concentrating on smoking cessation and vaccination for respiratory conditions, and referral to healthy housing. Other priorities include effective use of POAC and greater use of patient portals to improve efficiency of delivery of care. Management of cardiovascular risk factors for both primary and secondary prevention is also a priority.

The plan has been developed using a medium term approach. It includes immediate activity that will contribute to goals to be achieved within three years. This year we continue to support the essential work that is the foundation for quality improvement activities, including enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2020/21 continue to adopt a prevention approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

ENABLERS TO CAPACITY AND CAPABILITY

SYSTEM LEVEL MEASURES 2020/21 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	3% reduction for total population by 30 June 2021. 3% reduction for Māori populations by 30 June 2021. 3% reduction for Pacific populations by 30 June 2021.
Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	3% reduction for Māori populations by 30 June 2021. 3% reduction for Pacific populations by 30 June 2021.
Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021. Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.
Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	6% reduction for each DHB (on 2013 baseline) by 30 June 2021.* 2% reduction for Māori and Pacific by 30 June 2021. * Five year target set in 2016 to be achieved by 30 June 2021
Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	Increase coverage of chlamydia testing for males to 6% by 30 June 2021.
Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	2% relative increase in the proportion of babies living in smoke free homes by 30 June 2021.

IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan and contributory measures for the six SLMs for 2020/21. Improvement activities create change, improvement in contributory measures and contribute to improved outcomes in the various SLM milestones. For 2020/21, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Ambulatory Sensitive Admissions in 0-4 year olds	
Activities	**Contributory Measures**
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori children. Target 30%. Influenza vaccination rates for eligible Pacific children. Target 30%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist. • Implementing the Best Start Pregnancy Tool so it can function as a pregnancy register in primary care. • Set primary care recalls for pregnant women to ensure they have developed a relationship with a midwife. • Improve the flow of health information by increasing usage of the Best Start Pregnancy tool by midwives. • Develop a process for making pertussis vaccination more readily available in primary care.	Influenza vaccine coverage rates for pregnant Māori. Target 50%. Influenza vaccine coverage rates for pregnant Pacific. Target 50%. Pertussis vaccine coverage rates for pregnant Māori. Target 50%. Pertussis vaccine coverage rates for pregnant Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Develop a baseline measurement of referrals to healthy housing with the aim of increasing referrals rates from primary care. • Prompt e-referral to Healthy Housing using Best Start Pregnancy, with a focus on pregnant low income Māori and Pacific women. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Percentage of practices that have Best Start Pregnancy tool installed. Target 30%. Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.
Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.	

Youth Sexual and Reproductive Health

Activities	Contributory Measures
Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by: • Increasing engagement with young people by working with general practices to encourage participation in the RNZCGP MOPS Youth Service audit. • Increased sexual health screening and funded sexual health consults for enrolled young people 15-24 years old (including screening for pregnant woman). • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist.	Percentage of practices with at least one GP who has completed an RNZCGP approved youth audit. Target 50%

Milestones: The Youth milestone will be improved by these activities.

Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions in Counties Manukau Health through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Provide general practices with localised resources, training and effective tools to support the systematic and equitable delivery of alcohol ABC to their enrolled population. • Improve data collection capability to multiple practice management systems.	Percentage of the enrolled population aged 15 years and over with alcohol status documented. Target 55%.

Milestones: The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

Smoking Cessation for Māori and Pacific

Activities	Contributory Measures
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals received by cessation support providers and rates of cessation medication therapy prescribed in primary care. • Audit a selection of practices to ensure referral data is accurate • Develop a surveillance report to monitor smoking prevalence by ethnicity and age. • Develop a report to monitor cessation rates by practice. • Query build lists of pregnant women coded as smoking to update smoking brief advice and direct them into cessation support programmes. • Assuring those who have been prescribed cessation medications are followed up by the local smokefree team for support with medication adherence & quitting. • Identify role of RN in Quit Smoking and upskill by completing a fast-track version of the National Training Standards Programme for smoking cessation. Ensure at least one person is trained per practice.	Rate of referral to smoking cessation providers by PHO. Target 6%. Rate of prescribing of smoking cessation medications by PHO. Target 12%.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. Practices will set recalls and screen patients.	CVDRA rates for Māori. Target 90%.
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible, receive the funded influenza vaccination. Monitored by DHB and ethnicity. • Implement a regionally agreed process to identify at practice level, high risk patients who are not taking recommended medications and record where medications are not tolerated or patients have declined treatment. Reporting and improvement of clinical management through prescribing is facilitated through: • Comparing dispensing data to prescribing data and identifying any opportunities for improvements. • Specific actions will be developed after the analysis is complete. Opportunities to improve data collection and quality are advanced through: • Continue with a pilot focused on coding specified conditions (e.g. IHD, AF, CKD, diabetes). The results, expected in the next six months will inform further activities.	Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%. Percentage of Māori with a CVD risk over 20% who are prescribed dual therapy. Target 60%.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

Complex Conditions and Frail Elderly

Activities	Contributory Measures
Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: • Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination. Improve coding in primary care for specified long term and complex conditions (e.g. COPD and CHF) by matching ICD10 codes from secondary care with PHO registers and developing a process to supplement coding as clinically appropriate.	
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme by: • PHOs to promote the uptake of falls prevention screening templates in all primary care patient management systems. • Development of an updated Goodfellow Unit falls prevention webinar. • DHBs to support contracted programme providers to engage directly at a general practice level to increase the profile of the falls prevention programme, prioritising practices with a high proportion of older people in their enrolled population.	Percentage of patients aged 75 years and over (65 years for Māori and Pacific) who have been screened for falls risk. Target 50%.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice. • Focusing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Develop regular reports for PHOs on POAC usage	POAC initiation rate in primary care. Target 3 per 100 for each PHO. Report by ethnicity
Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.	

E-portals

Activities	Contributory Measure
Continued support for patient enrolment (logon) to e-portals by practices (given that unique email addresses are a critical dependency) by carrying out the following activities: • Receptionist training and socialisation. • Linking with practice accreditation processes.	Percentage of each PHO's enrolled population with login access to a portal. Target 30%.
Milestones: The Patient Experience of Care milestone will be improved by these activities.	

Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focused on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice. • Develop processes for collection and monitoring of email addresses for Māori and Pacific patients.	Percentage of Māori and Pacific patients eligible for the primary care patient experience survey who have valid email addresses. Target 40%.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Create training package in conjunction with a Health Psychologist for all hospital pharmacists and student pharmacists with links to patient experience, multidisciplinary team relationships, framing and communication approaches. • Development of Health Navigator resources and online resources. • Development of an acute pain management discharge checklist. • Testing of electronic solutions via Medchart to prompt patient conversations. • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB). • Sharing learnings with primary care through established networks and forums. Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above. Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	ADHB/WDHB Percentage of hospital pharmacists will have completed the medication safety training package. Target 50%
Milestones: The Patient Experience of Care milestone will be improved by these activities.	

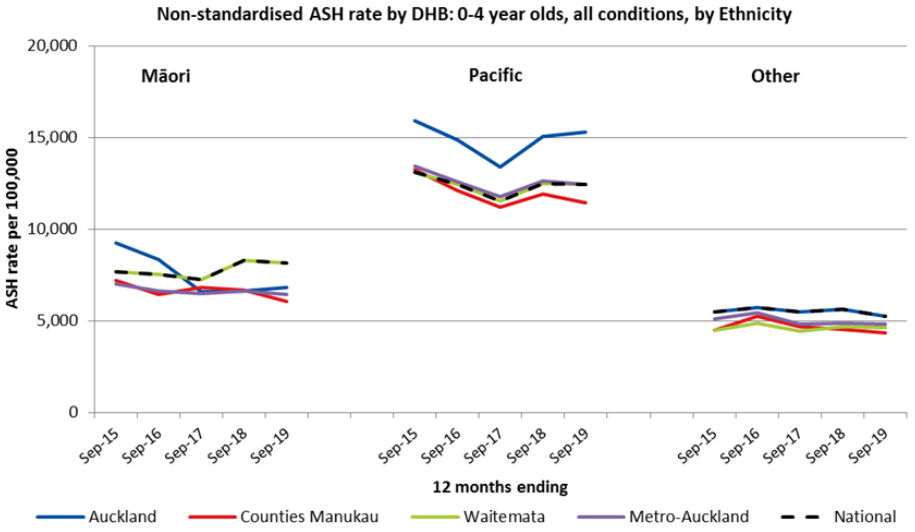
SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

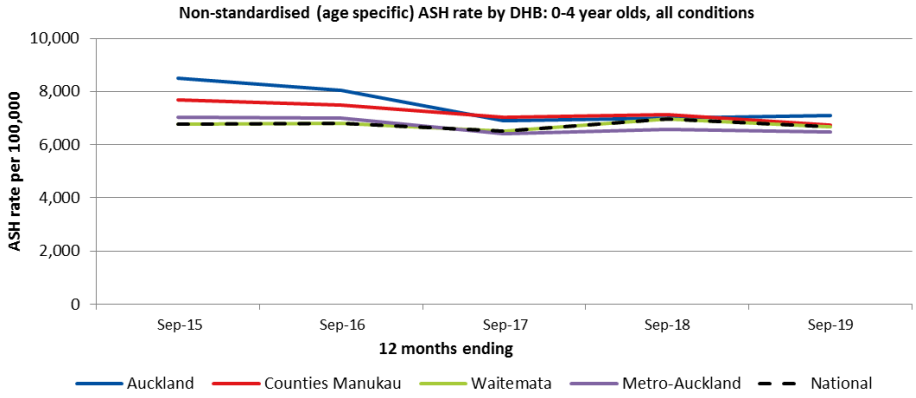
Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	3% reduction for total population by 30 June 2021.
	3% reduction for Māori populations by 30 June 2021.
	3% reduction for Pacific populations by 30 June 2021.

Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches.

In addition to paediatric and maternal immunisation, smoking cessation and improving the housing environment are important for improving this milestone. This year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs.

We plan to build on improvements in immunisation rates and spread the methodology to other high risk cohorts which will improve outcomes in acute hospital bed days.





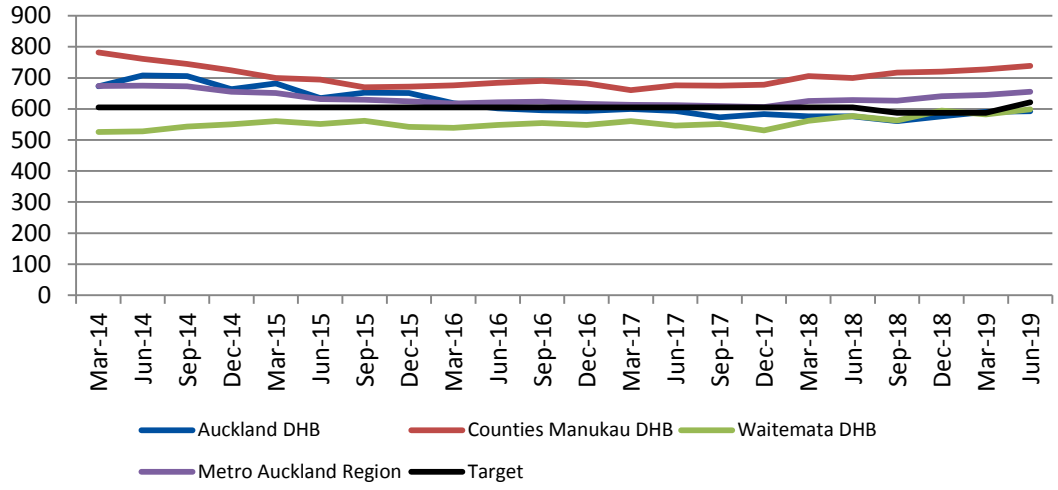
This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	3% reduction for Māori population by 30 June 2020. 3% reduction for Pacific population by 30 June 2020.

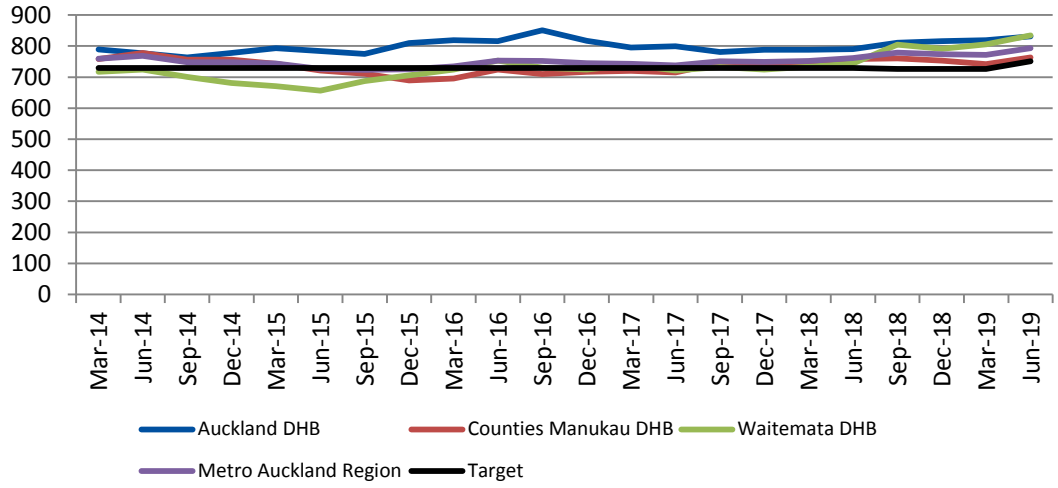
Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted. Total acute hospital bed days for 2019/20 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021. Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.

Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

The 2020/21 plan continues to look at performance of individual questions rather than response rates to the survey.

The patient experience surveys have been significantly disrupted during 2019/20 with:

A refresh of the survey precluding direct comparison of questions between the old and new surveys

A change in provider contributing to a pause in delivery of the survey and discontinuous data flow

The COVID-19 crisis which further contributed to pausing the survey and also resulted in a significant changes in the way patients accessed primary care

Hospital Inpatient PES: The medication side effect question has been modified for the recent inpatient survey. At the time of submission of this plan data was not available for the modified question. It is highly likely that the communication of medication information will continue to be an area for improvement for the total population and also for Māori.

The milestone for 2020/21 will continue to focus on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by education of multidisciplinary teams focusing on patient empowerment, health literacy, and equity. A baseline will be established and improved upon when the first survey is conducted using the new survey.

Primary Health Care PES: The PHC PES is also well established in primary care. In keeping with the aim of reducing inequality the question about individual or cultural needs was chosen. This question has been introduced in the new survey and again a baseline will be established with the first round of the survey. Patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients and will promote cultural awareness.

Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	6% reduction for each DHB (on 2013 baseline) by 30 June 2021. 2% reduction for Māori and Pacific by 30 June 2020.

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation.

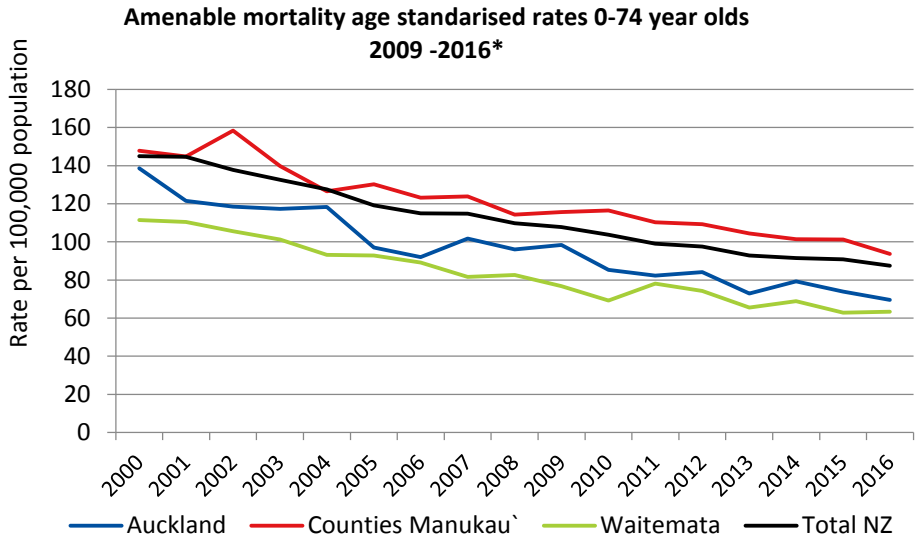
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

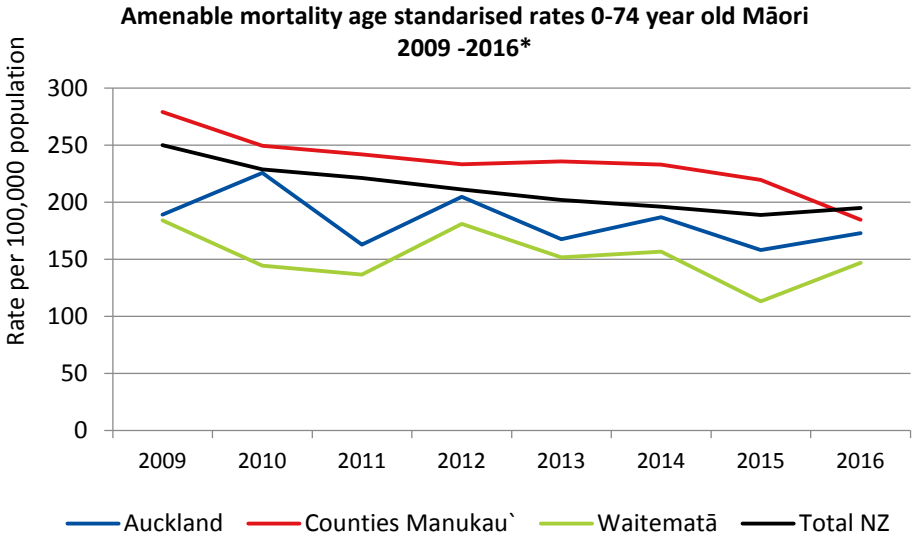
In 2020/21 we aim to build on the work done in implementation of the new Consensus Statement for Assessment and Management of CVD. With the risk assessment algorithms available to primary care there will be a stronger emphasis on risk assessment for Māori and primary prevention for those at greatest risk. We continue to focus on secondary prevention for this population.

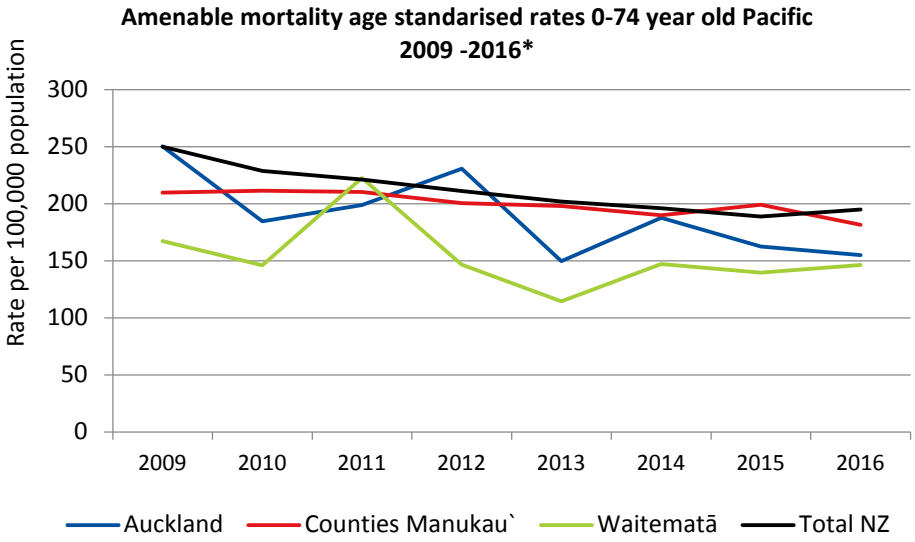
Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Through the use of data sharing we can focus on referrals to smoking cessation services by practitioners in different parts of the health system.

The 2020/21 plan will build on the successful implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.




Amenable mortality age standarised rates 0-74 year old Māori
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

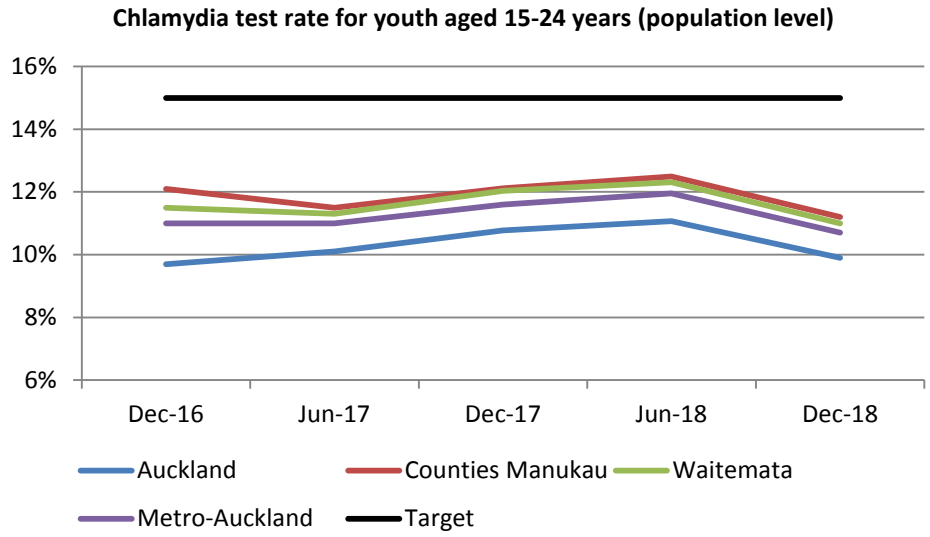

Amenable mortality age standarised rates 0-74 year old Pacific
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	Increase coverage of chlamydia testing for males to 6% by 30 June 2021.

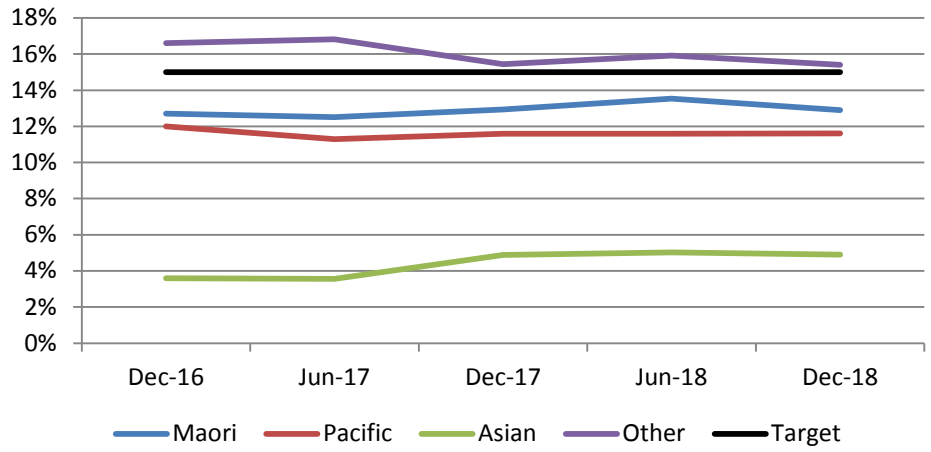
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviors, in terms of drug and alcohol abuse and criminal activities.

Chlamydia testing coverage: This is an indicator of young people's access to confidential youth appropriate comprehensive healthcare. For those young people 15 years and older who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non-Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender. While we aim to increase screening rates for all youth there is a focus on improving rates for males.



Chlamydia test rate for youth aged 15-24 years by ethnicity (population level) - metro-Auckland DHBs

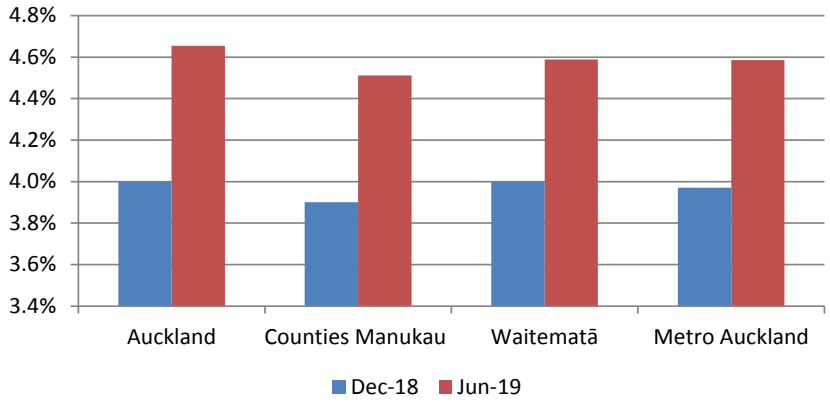


Chlamydia testing coverage in 15-24 year old males

Results for the 6 month period to June 2019: males only.

DHB	Ethnicity	No of people having chlamydia tests	Population	Chlamydia test rate (%)
Auckland	Māori	184	4,230	4.3
	Pacific	244	5,480	4.5
	Asian	256	16,480	1.6
	Other	1,344	17,380	7.7
Counties Manukau	Māori	454	8,700	5.2
	Pacific	553	11,500	4.8
	Asian	261	9,880	2.6
	Other	663	12,720	5.2
Waitematā	Māori	263	6,110	4.3
	Pacific	190	4,170	4.6
	Asian	161	9,270	1.7
	Other	1,387	24,060	5.8
Metro-Auckland	Māori	901	19,040	4.7
	Pacific	987	21,150	4.7
	Asian	678	35,630	1.9
	Other	3,394	54,160	6.3

Chlamydia test rate for males in the 6 months to Dec 18 and Jun 19 by DHB



Babies in Smokefree Homes

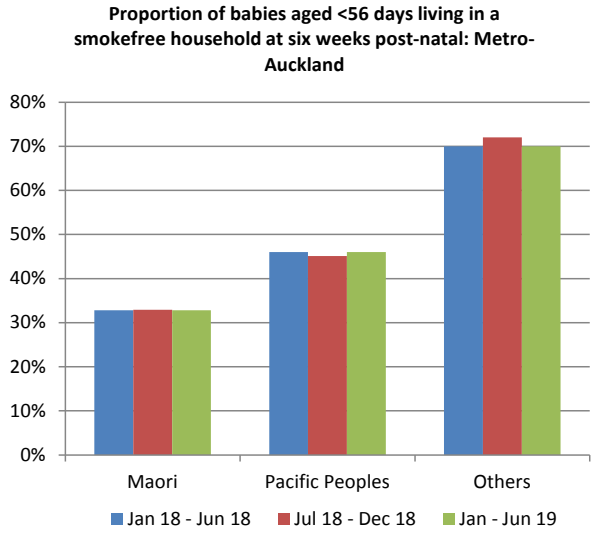
System level outcome	Healthy start
Improvement milestone	Increase the proportion of babies living in smokefree homes by 2%

The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period		DHB of domicile		
	Metro-Auckland	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
2019/20 Targets	**60.7%**	**68.2%**	**53.9%**	**63.2%**

There is still some work to be done, as data does not reflect live births. This may be improved by an increase in the proportion of births enrolled with WCTO providers. This work should support both smoking intervention in pregnancy and the post-natal period, and continued quality data collection in the Well Child Tamariki Ora space.



Fewer Māori babies live in smokefree homes. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.

Our work will be supported by earlier identification of smoking in pregnancy and referral to services for pregnant women and their whānau.

GLOSSARY

ABC	Assessment, Brief Advice, and Cessation Support
ADHB	Auckland District Health Board
AF	Atrial Fibrillation
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory Sensitive Hospitalisations
A/WDHB	Auckland and Waitematā District Health Boards
CHF	Coronary Heart Failure
CKD	Chronic Kidney Disease
CME/CNE	Continuing Medical Education/Continuing Nursing Education
CMH	Counties Manukau Health (referring to Counties Manukau District Health Board)
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVD RA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
ED	Emergency Department
GP	General Practice/General Practitioner
HQSC	Health Quality Safety Commission
IHD	Ischaemic Heart Disease
IMAC	Immunisation Advisory Centre
LMC	Lead Maternity Carer
MACGF	Metro Auckland Clinical Governance Forum
MADSF	Metro Auckland Data Sharing Framework
PDSA	Plan, Do, Study, Act
PES	Patient Experience Survey
PHC PES	Primary Healthcare Patient Experience Survey
PHO	Primary Healthcare Organisation
PMS	Practice Management Systems
POAC	Primary Options for Acute Care
SLM	System Level Measure
SMI	Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)
STI	Sexually Transmitted Infection
UK	United Kingdom
WDHB	Waitematā District Health Board
WCTO	Well Child Tamariki Ora

APPENDIX E: DHB BOARD AND MANAGEMENT

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

Board members	Pat Snedden, Chair	(appointed)
	William (Tama) Davis, Deputy Chair	(appointed)
	Bernie O'Donnell	(appointed)
	Michael Quirke	(appointed)
	Jo Agnew	(elected)
	Douglas Armstrong	(elected)
	Michelle Atkinson	(elected)
	Peter Davis	(elected)
	Fiona Lai	(elected)
	Zoe Brownlie	(elected)
	Ian Ward	(elected)

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

Executive 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
	Dame Rangimarie Naida Glavish	Chief Advisor Tikanga (Auckland, Waitematā DHBs)
	Rosalie Percival	Chief Financial Officer
	Mel Dooney	Chief People Officer
	Shayne Tong	Chief of Digital Officer
	Mark Edwards	Chief Quality, Safety and Risk Officer
	Meg Poutasi	Chief of Strategy
	Joanne Gibbs	Director of Provider Services
	Dr Debbie Holdsworth	Director of Funding (Auckland, Waitematā DHBs)
	Dr Karen Bartholomew	Director of Health Outcomes (Auckland, Waitematā DHBs)
	Nigel Chee	General Manager Māori Health (Auckland, Waitematā DHBs)
	Vacancy	General Manager, Pacific Health (Auckland, Waitematā DHBs)
Children's Health Directorate	Dr Michael Shepherd	Director
Mental Health and Addictions Directorate	Anna Schofield	Director
Adult Medical Services Directorate	Dr Barry Snow	Director
Adult Community and Long Term Conditions Directorate	Lalit Kalra	Interim Director
Cancer and Blood Directorate	Dr Richard Sullivan	Director
Perioperative Services Directorate	Dr Vanessa Beavis	Director
Surgical Services Directorate	Dr Arend Merrie	Director
Cardiac Directorate	Dr Mark Edwards	Director
Women's Health Directorate	Angela Beaton	Director
Clinical Support Services Directorate	Ian Costello	Director

APPENDIX F: GLOSSARY

ACC	Accident Compensation Commission
AOD	Alcohol and Other Drugs
ARDS	Auckland Regional Dental Service
ASH	Ambulatory sensitive hospitalisation
B4SC	Before School Checks
CADS	Community Alcohol, Drug and Addictions Service
CAMHS	Child, Adolescent Mental Health Service
CT	Computerised tomography
CVD	Cardiovascular disease
DNA	Did not attend
ECE	Early childhood education
ED	Emergency Department
EOA	Equitable outcomes action
FTE	Full time equivalent
GP	General Practitioner
HQSC	Health Quality & Safety Commission
Inequality	Differences in health status or in the distribution of health determinants between different population groups (WHO definition)
Inequity	Avoidable inequalities in health between groups of people, whether the groups are defined socially, economically, demographically or geographically (WHO definition)
Iwi	Tribe
Kaupapa	Agenda
Kōhanga Reo	Māori language nest
LMC	Lead Maternity Carer
LOS	Length of stay
Mana whenua	People who have authority over the land
MH	Mental health
MoH	Ministry of Health
MOU	Memorandum of Understanding
MRI	Magnetic resonance imaging
NGO	Non-governmental organisation
NRA	Northern Region Alliance (North and Northern Region DHB support Agency)
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care
Q1, Q2, Q3, Q4	Quarters 1–4, i.e. by 30 September, 31 December, 31 March or 30 June
QALY	Quality-adjusted life year
RFP	Request for proposal
Te Runanga o Ngāti Whātua	Ngāti Whātua Tribal Council
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention
WCTO	Well Child/Tamariki Ora
Whānau	Extended family
Whānau Ora	Families supported to achieve their maximum health and wellbeing
YTD	Year to date