TE TOKA TUMAI
Auckland DHB

Annual Plan 2021/22

Auckland District Health Board

Incorporating the 2019/20-2022/23 Statement of Intent and 2021/22 Statement of Performance Expectations

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 2021/22 is signed for and on behalf of:

Auckland District Health Board

Pat Snedden
Chair

William (Tama) Davis
Deputy Chair

Ailsa Claire
Chief Executive

Our Te Tiriti O Waitangi Partner
Te Runanga o Ngati Whātua

Dame Rangimarie Naida Glavish, DNZM JP
Chair, Te Runanga o Ngati Whātua

Kōtui Hauora, Northern Iwi-DHB Partnership Board

Gwen Tepania-Palmer
Chair

And signed on behalf of:
The Crown

Hon Andrew Little
Minister of Health

Date
17 November 2021

Hon Grant Robertson
Minister of Finance

Date
17 November 2021

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
Pat.Snedden@adhb.govt.nz

17 November 2021

Tēnā koe Pat

Auckland District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Auckland District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Keeping COVID-19 out of communities.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also acknowledge the importance of your Board delivering on the Plan in a fiscally prudent way.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

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 (the Ministry), including changes in FTE. 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 also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

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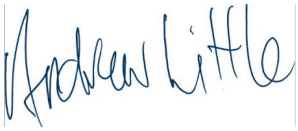
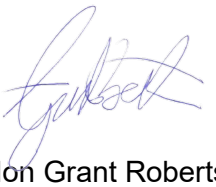
Please ensure that a copy of this letter is attached to any copies of your signed Plan made available to the public.

Nāku noa, nā





Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Ailsa Claire
Chief Executive of Auckland DHB

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Foreword from our Board Chair and Chief Executive

COVID-19 showed us that health services are much more than the technical ability to meet the challenge of illness. More than this, they are a reflection of our confidence in New Zealand society.

As citizens, we know that when we are under maximum pressure, we can rely on our health agencies when we are ill to act together to deliver the care needed.

This pandemic opened us up to the power of kindness and the value of placing the welfare of others on a par with our own welfare. We are successfully negotiating the enduring threat of this virus because we choose to stick together as a nation. Nowhere has this been better exemplified than in our health system.

Long before the new health reforms were announced, the Northern Region has been acting as a collective force to arrange better care for all within the northern boundaries. We are already part way on the path towards where the new reforms take us.

We launched Kōtui Hauora in late 2019 and, within months, the value of this DHB-iwi partnership showed co-operation, leadership and courage to protect the northern populations from COVID-19. The value of shared decision making and support for Māori to implement agreed health plans, with the authority to spend, kept us all safe. This is an indication of what is intended with the Māori Health Authority. The value of such thinking was exemplified in our response to the virus.

We can all be justly proud of what we achieved at Auckland DHB throughout the last year in response to COVID-19, kicking off the vaccine roll-out and managing some of the highest demand for hospital services.

We anticipated the changes announced by the Minister of Health, which will affect the future of the New Zealand health system. These reforms are ambitious but feel like the right ones to ensure we create an even better health system for all New Zealanders. There is no doubt it will be a challenge to move from what we have today to what the Minister outlined under Health NZ and the Māori Health Authority.

However, such a monumental change in health brings with it a great opportunity to rethink what does not work well enough for our fellow citizens. We now have ample data and analysis on the equity gaps in service for Māori. The new Māori Health Authority will have the capacity to help address this constitutional shortfall for our Māori populations.

Our focus at Auckland DHB is to enact our Te Tiriti responsibilities to protect the rights that Māori hold as tangata whenua and to ensure we achieve equitable health outcomes for Māori. We will do this in partnership and with the continued commitment and professionalism of our Auckland DHB people. Our DHB Board, iwi and other stakeholder organisations are identifying the activities needed to drive change.

There is no doubt that this will be a year of considerable transformation as we interrogate our services and practices to make equity synonymous with quality.

We want to reassure those working at Auckland DHB that your best interests are in our frame during this transition. The changes that will materialise may disrupt, but there will be great opportunities for the use of all of our skills.

This year we will continue to have a strong focus on prevention and population health, as well as improved and timely access to treatment. The wellbeing of everybody we treat is important to us and we know that our people's experience affects patient experience and health outcomes. We will continue to strengthen a positive workforce culture that supports our people to thrive and be at our best for patients, whānau and each other.

It is another big year ahead, but we have an amazing team of people who we know will be ready to embrace the opportunities.

Pat Snedden

Chair, Auckland District Health Board

Ailsa Claire OBE

Chief Executive, Auckland District Health Board

Message from the Chair of Kōtui Hauora, our Iwi-DHB Partnership Board

E ngā iwi, e ngā karangatanga maha, tēnā koutou

E ngā mate kua mene ki te pō, haere, haere, haere

Ka huri matou ki te hunga ora, tēnā koutou katoa

Ngā mihi maha hoki ki a koutou, mānawatia a Matariki

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Matariki 2021 brings us into the second year of Kōtui Hauora, a Tiriti-based partnership of mutual benefit between iwi across Te Tai Tokerau and the three northern most DHBs. Although we have a long journey ahead, I look back on the year that was with admiration for all involved and the work achieved for whānau and communities. It was truly inspiring to see how we, as a team, responded to the COVID-19 pandemic.

The impact from COVID-19 really put our partnership to the test and I am proud to say that we responded brilliantly. With the support of Kōtui Hauora, our iwi partners throughout the north provided necessities and home-based care to over 23,000 households, set up a COVID-19 coordination hub, and employed 90 Kaimanaaki as their frontline workforce to engage with whānau in the community. Ngā Kaimanaaki based with iwi conducted over 5,000 whānau wellbeing assessments and assisted them to access healthcare and social support. This massive effort was funded by a number of agencies, with Northland, Waitematā and Auckland DHBs providing a large part of this investment. The success was so great from these efforts that further support and investment will be made into Ngā Kaimanaaki services.

The wider sector response is also important to acknowledge. It was great to see Māori-led pop-up clinics in communities, outreach support services and testing sites across Te Tai Tokerau. In Auckland and Waitematā, Māori-led outreach services, supported by Kōtui Hauora, provided healthcare in vulnerable communities. A big part of this included influenza vaccinations for Māori. In 2020, the coverage for influenza vaccination for Māori aged 65 years and over increased by 7.7% in Auckland DHB and by 13.1% in Waitematā DHB compared with 2019 coverage. This is a good outcome, and shows that we need to continue to work together to engage and care for our communities.

Kōtui Hauora is about action in the face of need, and we firmly believe that this requires our collective resource, knowledge and influence to achieve. I am heartened to see that we are building on the progress we made in 2020 in the coming financial year. On behalf of Kōtui Hauora, I look forward to seeing the actions in the Annual Plan progress over the next 12 months and beyond.

Kia pūmau tā tātou hononga, kia haere tonu ā tātou mahi

(Our partnership will endure and our work will continue.)

Gwen Tepania-Palmer

Chair, Kōtui Hauora, Northern Iwi-DHB Partnership Board

Introduction

Auckland DHB | Te Toka Tumai is the Government's funder and provider of health and disability services across the system, mai te whenua ki te whenua mō te katoa. We serve an estimated 511,000 residents who live in the Auckland isthmus, Waiheke Island and Great Barrier Island, as well as providing specialist healthcare services to patients and whānau from the Northern Region, across districts, and Aotearoa New Zealand.

Our population is increasingly diverse and rapidly growing. Just over 8% of Auckland residents are Māori, 11% are Pacific, and 35% are Asian (projected 2021/22 population; 2020 update). Around 45% of our population were born overseas, with over 200 languages spoken. Our population is growing and is projected to increase by 8% (43,000 people) over the next ten years.

Auckland DHB'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 Te Papakāinga Atawhai o Tāmaki, Auckland City Hospital, the largest teaching hospital and research centre in New Zealand. We provide many highly specialised services to the motu.

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.

Around 12,000 people are employed by Auckland DHB. In 2021/22, we have an expenditure budget of $2.9 billion.

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

DHBs act as planners, funders and providers of health services, as well as owners of Crown assets. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus in our district. The identified needs are balanced alongside national and regional priorities and funding constraints to plan the optimum arrangement for effective and efficient delivery of health services.

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

This Annual Plan articulates Auckland DHB's commitment 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***, and to the expectations of the Minister of Health's priorities in delivering improved wellbeing and equity.

Section Two details the key activities we will deliver to address the planning priorities identified by the Minister for 2021/22.

Delivering equity and outcome improvements for our Māori, Pacific and other under-served populations will underpin all of our actions in 2021/22. We have a strong focus this year on prevention and population health, as well as improved and timely access. Sustainability and strong fiscal management are key to delivering these goals.

2021/22 will be a time of preparation and transition as we progress towards the new health service model, announced in April 2021 in response to the Health and Disability Services Review. Auckland DHB will continue to deliver all of our usual services in 2021/22, but will begin to work towards implementation of the new model. We intend for our organisation to be in the best possible position to facilitate the transition to Health NZ.

This plan was prepared in accordance with Section 38 of the NZ Public Health and Disability Act 2000. A renewed Statement of Intent (SoI) is not required for 2021/22; we have therefore only made minor updates to our SoI, presented in Appendix A. Detailed reporting, including Financial Performance and the Statement of Performance Expectations for 2021/22, is also contained in the appendices.

COVID-19

COVID-19 is having a material impact on the way we plan and deliver services. Our challenges are to recover and grow from the outbreaks experienced in 2020, and continue to participate in the current COVID-19 response work and the delivery of a comprehensive vaccination programme.

Our people are engaged in significant work programmes to clear the backlog of activity that was deferred during the 2020 lockdowns and return access and participation rates to levels seen prior to COVID-19.

As a result of the COVID-19 lockdowns, we are experienced in delivering and support increased telehealth in the longer term by developing more electronic tools to assist with the delivery of virtual and

paperless clinics.

Together with Northland DHB and the other Metropolitan Auckland DHBs, we operate a regional public health response through the Northern Regional Health Coordination Centre (NRHCC). The NRHCC is responsible for community COVID-19 testing and outbreak control, surveillance testing of all border workers and the entire health component of the Managed Isolation and Quarantine system in the Northern Region.

DHBs are responsible for delivering New Zealand's largest ever immunisation roll-out. The NRHCC oversees the set-up and operation of community vaccination centres all over Auckland, and Auckland DHB staff help to man both the community and staff vaccination clinics. As part of the regional work programme, Auckland DHB is committed to completing the roll out of the COVID-19 vaccination programme and ensuring its success.

Our first large-scale COVID-19 vaccination clinic opened in South Auckland on 9 March 2021 to vaccinate household contacts of border staff and managed isolation and quarantine workers. Several more large-scale centres, capable of vaccinating up to 1,000 people a day, have opened across greater Auckland. There are Pacific-focused vaccination centres in Otara and West Auckland, and a Māori-led vaccination centre at Manurewa Marae. We are working in partnership with Māori and Pacific NGOs to set up more small, community-based vaccination centres.

Kaumātua were among the first people to be vaccinated at the Manurewa Marae clinic.

Vaccination of those living in aged residential care began in late April 2021, starting with those living in the South Auckland communities highlighted as a priority within the national vaccination programme.

Many GP practices and Urgent Care facilities are now delivering vaccines. The Waiheke Island Medical Centre was the first GP practice clinic to begin vaccinating its patients against COVID-19 in May 2021, with many more planned to open over the coming months.

The Auckland DHB staff vaccination clinic opened in March 2021, in line with the Government's COVID-19 vaccination plan, and by early May 2021 46% of staff were fully vaccinated.

As at 20 June 2021, 352,000 vaccinations were delivered across Metro Auckland, achieving 89% of the planned volume. Around 74,000 Auckland residents received at least one dose. Vaccine delivery is expected to ramp up quickly between July and December 2021, and we are currently on track to deliver our planned vaccination volumes.

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 people and more highly deprived communities (ranked as quintiles 4 and 5, NZDep2018) experience inequalities in health outcomes. One in five (18%) of our total population, 29% of our Māori population and 45% of our Pacific population live in areas ranked as highly deprived (NZDep2018). 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. We know that inequity is not only avoidable but unfair and unjust. Māori are guaranteed rights under Te Tiriti o Waitangi, which means attention to our Tiriti 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.

Eliminating inequity for Māori, and separately for Pacific peoples, is a strategic priority for Auckland DHB, as we enter the next few years of transition. In responding to the fluid environment in 2020, Auckland set a new strategic plan focused on a short-term horizon. Our Board, iwi and other stakeholder organisations are identifying the activities needed to drive change to improve health outcomes. While we continue to deliver all of our usual services, on 1 July 2022 we will progress into the new structure and national health service model. In 2021/22, our key priorities for equity are to:

- enact Tiriti 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 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 has developed a new Māori Health Plan, Whakamaua: Māori Health Action Plan 2020-2025, 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 also guided by the national Māori Health Strategy Korowai Oranga.

We are committed to eliminating inequity for Pacific peoples. We are reviewing our systems to find barriers that deny our Pacific people equitable access. We have 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. We will continue to enable other directorates to reorganise service delivery to achieve equity. This work is steered by Ola Manuia 2020-2025: Pacific Health and Well-being Action Plan.

We also focus on improving equity for disabled and older people. We are committed to the New Zealand Disability Strategy and the principles of the United Nations Convention on the Rights of Persons with Disabilities, and the Healthy Ageing Strategy.

Te Tiriti o Waitangi

Auckland DHB recognises Te Tiriti o Waitangi (Te Tiriti) as the founding document of Aotearoa New Zealand. We commit to the intent of Te Tiriti that established Iwi as equal partners with the Crown.

We acknowledge and draw on the Ministry of Health's position on Te Tiriti expressed by Mana Whakahāere, Mana Motuhake, Mana Tangata and Mana Māori, as well as the invigorated Tiriti principles recommended by the Waitangi Tribunal's Hauora report (Wai 2575 stage one).

Te Tiriti provides a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, is responsive to the needs of Māori communities, achieves equitable health outcomes for Māori and other high priority members of our communities.

We recognise the importance of our Memoranda of Understanding (MOU) partner, Te Rūnanga o Ngāti Whātua, in the planning and provision of healthcare services.

Article 1: Kawanatanga (governance)
Mana whakahāere: effective and appropriate stewardship or kaitiakitanga over the health and disability system. This relates to health system performance, particularly oversight and ownership of the processes necessary to reduce Māori health inequity. It provides active partnerships with mana whenua at a governance level. Providing for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

Article 2: Tino Rangatiratanga (self-determination)
Mana motuhake: enabling the right for Māori to be Māori, exercise their authority over their lives and to live on Māori terms, according to Māori philosophies, values and practices, including Tikanga Māori. This is concerned with opportunities for Māori leadership, engagement, and participation in DHB activities. Further, to foster and develop the capacity of Ngāti Whātua and Māori to have meaningful leadership and participation at every level of governance and operations within the DHB framework.

Article 3 – Oritetanga (equity)
Mana Tangata: achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness. This is concerned with achieving health equity, and thus with priorities directly linked to reducing systematic inequalities in health determinants, health outcomes and health service utilisation. Ngāti Whātua will hold the DHB to account and demand action to reduce health disparities in wellbeing that exist between Māori and non-Māori by improving health outcomes of Māori within their rohe, cognisant that 'wellbeing' is not simply the absence of illness and disease and that this will require dismantling systems and practices that have exasperated those health disparities.

Article 4 – Te Ritenga (right to beliefs and values)
Mana Māori: enabling Ritenga Māori (Māori customary rituals), which are framed by te ao Māori (the Māori world), enacted through Tikanga Māori (Māori philosophy and customary practices) and encapsulated within māturanga Māori (Māori knowledge). This guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga. Auckland DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities. Ensuring tikanga Māori is to the fore in the evolution of a more responsive model of care that prioritises Māori whānau, hapū, iwi and communities.

Te Toka Tumai 2020-2023 – our strategy

We have five strategic priorities over the coming three years. They are:

Under each domain, we align our work in our provider and in our community-based services. This includes elements of a future vision, metrics and key actions. These plans operate at different levels to cover the spectrum of large strategic programmes, portfolios, and/or operational business. With shifts in the volume of work in response to COVID-19, the majority of the transformation work is targeted at the first two priority areas.

There are four oranisational pillars that enable us to target our priorities:

1. Pūmanawa Tangata – People, culture and values
2. Quality, Safety and Risk
3. Commissioning services to meet our people's needs
4. Financial sustainability.

To deliver our priorities, we work in partnership with our MOU partner Te Runanga o Ngāti Whatua. We also work in co-governance with the regional leadership of Kōtui Hauora, as we build our capability to implement substantive change under our first priority and improve Māori health outcomes.

National, regional and sub-regional strategic direction

Auckland DHB operates as part of the New Zealand health system and is one of four DHBs in the Northern Region. 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 align with the Minister's expectations and the Government's priority outcomes.

COVID-19

COVID-19 is a public health emergency and global pandemic. Aotearoa New Zealand's strategy is for the elimination of COVID-19. The aims are to eliminate chains of transmission in the community and contain any cases imported from overseas.

COVID-19 is fundamentally changing and challenging the way the New Zealand public health system responds, especially impacting how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (PHUs) are now integrated with the Ministry of Health (led by the COVID-19 directorate), including the National Investigation and Tracing Centre (NITC) and the common IT platform in the National Contact Tracing Solution (NCTS).

Each outbreak is delivering significant learning opportunities for all parties, and the Ministry will ensure these learnings are shared across the sector and incorporated into future responses and activities.

The Ministry is engaging with DHBs/PHUs to design and implement a national public health response to more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which a surge response is mounted anywhere in the motu and/or address future challenges.

Working with Counties Manukau Health, Waitemata and Northland DHB, the region is delivering a 'whole of health system' response to COVID-19. This collaborative work is enabling rapid change and evolution in models of care across tier 1 and tier 2 services and has created an imperative to focus on faster, shorter, lifecycle projects and initiatives that will deliver change.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities. The delivery of a swift, effective and comprehensive vaccination roll-

out programme will be a key piece of work for the Health System in 2021/22.

Health and disability system reform

As a result of the findings of the 2018 Health and Disability Review, Aotearoa New Zealand's health system is changing. At the end of March 2021, Cabinet agreed a new operating model for the health and disability system.

The vision is for a health system delivering *pae ora | healthy futures* for all New Zealanders, where people live longer in good health and have an improved quality of life. To achieve this vision, the new system aims to achieve five outcomes above all others.

- Equity for all New Zealanders, so that people can achieve the same outcomes and have the same access to services and support, irrespective of who they are or where they live.
- Sustainability, through refocusing the system to prevent and reduce health needs and not just treat people when they are unwell: 'wellness not illness', and ensuring that we use resources to achieve the best value for money.
- Person and whānau-centred care, by empowering people to manage their own health and wellbeing and putting them in control of the support they receive.
- Partnership, through embedding the voice of Māori and other consumers into how the system plans and makes decisions, ensuring that Te Tiriti o Waitangi principles are meaningfully upheld.
- Excellence, ensuring consistent, high-quality care is available when people need it, and harnessing leadership, innovation and new technologies to the benefit of the whole population.

Improving outcomes for those traditionally underserved by our health system, Māori, Pacific and disabled people, our rural communities, and people with lower incomes (among others), is at the heart of these reforms.

To achieve *pae ora* and a more sustainable and better health system, there are five key shifts we must deliver.

1. The health system will reinforce Te Tiriti principles and obligations.
2. All people will be able to access a comprehensive range of support in their local communities to help them stay well.
3. Everyone will have access to high quality emergency or specialist care when they need it.
4. Digital services will provide more people with the care they need in their homes and local communities.
5. Health and care workers will be valued and well-trained for the future health system.

In 2022/23, all DHBs will be disestablished and their functions merged into a single entity, Health NZ.

Health NZ will manage all health services, including hospital and specialist services, and primary and community care. Hospital and specialist services will be planned nationally and delivered more consistently across the motu. Primary and community services will be commissioned through four regional divisions, each of which will network with a range of district offices (Population Health and Wellbeing Networks) who will develop and implement locality plans to improve the health and wellbeing of communities.

A Māori Health Authority will work alongside Health NZ to improve services and achieve equitable health outcomes for Māori, and to directly commission tailored health services for Māori.

2021/22 will be a time of preparation and transition as we progress towards the new model. DHBs will continue to deliver all of our usual services, but will begin to establish national, regional and locality structures and functions. We intend for our organisation to be in the best possible position to facilitate the transition to Health NZ.

Regional direction

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.

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.

Refer to Section 4 Stewardship, Northern Region Planning for further information.

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.

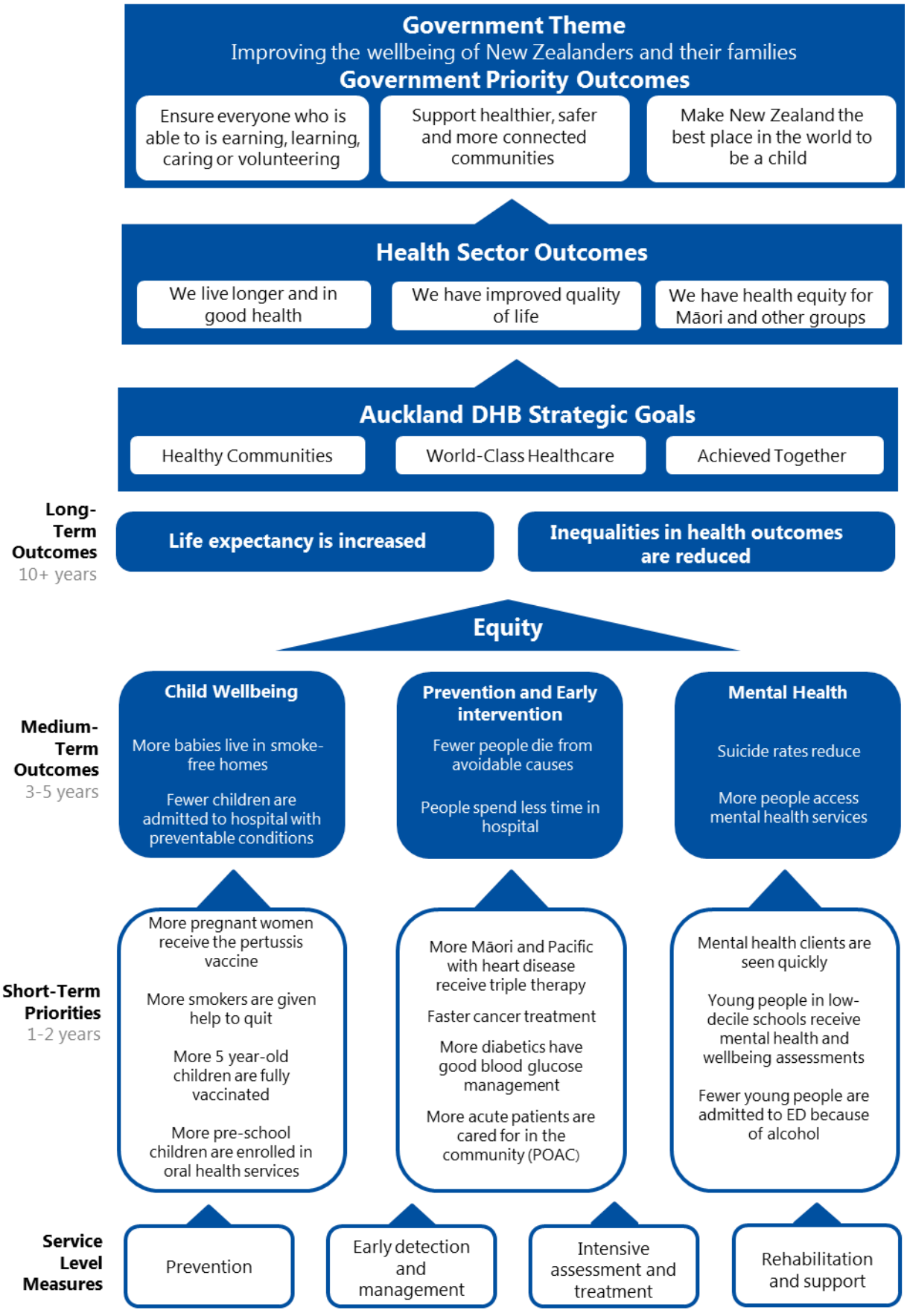
We have two overall long-term population health outcome objectives: life expectancy at birth continues to increase; and inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

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 February 2021, the Minister of Health set out DHB priorities for 2021/22. 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 achieve 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 department, except where the focus is provider specific. Responsibility for delivery may sit across multiple stakeholders and collaborative priority setting and accountability is critical.

Several 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.

This is the second year that the annual plan of the region's public health unit (PHU) is incorporated into the DHB annual plan.

Focus for 2021/22

The Ministry of Health has directed that equity and the COVID-19 response are the focus for actions in 2021/22 DHB annual plans.

Actions to improve equity

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

Actions related to COVID-19 response

Auckland DHB is committed to supporting New Zealand's elimination approach to COVID-19. The COVID-19 outbreaks in 2020 had a significant impact on the way we delivered all of our services, and we continue to gather learnings from our response and the experiences of our health system partners.

We will use this experience to improve the way we plan and deliver a wide variety of services, not just those relating directly to COVID-19, and actions arising from these learnings are detailed in this annual plan. This plan also includes actions relating to our response to any future resurgence, and actions to aid our recovery from the impacts of the pandemic.

Government Planning Priorities

Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

Whakamaua: the Māori Health Action Plan 2020-2025 was developed to achieve the vision of pae ora (healthy futures), set out in He Korowai Oranga, the Māori Health Strategy. 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

Action (all are EOA)	Milestone
Engagement and obligations as a Treaty partner Auckland DHB has an existing relationship with Ngāti Whātua. We will work to increase the frequency of engagement between our Boards and the Boards of our partners, especially in light of the COVID-19 vaccine roll-out that will require strong engagement with our iwi and community partners • Host two Board-to-Board meetings with our iwi/Māori partners	Q2, Q4
Support the development and implementation of the Northern Region's Health Equity Plan	Q4
Host training sessions for Auckland DHB Board, the topics will include (by quarter): Tiriti o Waitangi, racism and bias within the health system, Māori health inequities, and Mātauranga Māori	Ongoing
Whakamaua Action 1.1 Work with Kōtui Hauora (the Northern Iwi-DHB Partnership Board) to implement the actions from their work plan. This includes aligned DHB and iwi priorities for Māori health development and gain. These actions need to be resourced by the DHBs to be completed	Q4
Whakamaua Action 2.3 Design and deliver training to Māori DHB Board members and Kōtui Hauora members to improve their understanding of the system and to identify where opportunities exist. We are committed to creating a proactive and accountable system where Māori health equity is at the core of everything that we do. These leaders will have the influence and mana to support this to occur	Q4
Support two Māori DHB Board members to take up formal governance training opportunities	Q4

Whakamaua: Māori Health Action Plan 2020-2025
Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems

Action (all are EOA)	Milestone
Accelerate and spread the delivery of Kaupapa Māori and whānau-centred services *Whakamaua Action 3.1* Build and consolidate relationships with external organisations (e.g. Kia Ora Hauora) and pathways to strengthen kaimahi Māori workforce talent pipeline(s)	Q4
Whakamaua Action 4.4 For the seven kaupapa general practices identified for support as part of Integrated Primary Mental Health and Addictions Services: • Review delivery against models and consider amendments/improvements to better align the models to appropriate cultural delivery	Q3
Whakamaua Action 6.1 Partner with a Māori health provider to pilot a community-based telehealth pod to reduce telehealth barriers to access for Māori and improve uptake • Commence pilot	Q2
Shift cultural and social norms *Whakamaua Action 3.3* Establish a Tuakana – Teina mentoring programme to create mentorship opportunities for kaimahi Māori	Q4
Reduce health inequities and health loss for Māori *Whakamaua Action 4.7* Refer to the Smokefree 2025, Immunisation, Breast Screening and Cervical Screening sections	
Whakamaua Action 8.2 Kōtui Hauora is our Tiriti-based partnership with our iwi partners. Plans across the Northern Region DHBs will be discussed in depth with iwi through this mechanism; local plans will follow existing local iwi/Māori	

Whakamaua: Māori Health Action Plan 2020-2025 Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems	
Action (all are EOA)	**Milestone**
partnership engagement processes. We will work with Kōtui Hauora to understand their priorities for the next 1-5 years, and start the development of a work plan and allocate necessary resources to achieve tasks linked to their priorities. • Engage with iwi to understand their health and wellbeing priorities • Develop a work plan to capture these priorities and agreed associated actions • Agree and allocate resources to complete these actions	 Q1 Q2 Q2
Strengthen system accountability settings *Whakamaua Action 1.4* Partner with mana whenua in the development of a design manual for Auckland DHB to ensure the design of facilities are conducive with hauora Māori. Deliver design outcomes that build upon the cultural landscape maps and mana whenua ōranga narratives to provide culturally safe spaces for tikanga Māori, such as pōwhiri, whakatau and karakia, and have space for whānau who are caring for a person to be involved, included and supported in their care	 Ongoing; progress update Q4
Whakamaua Action 4.9 We are committed to supporting the Māori health sector to provide integrated and whānau-centred care that is accountable to the communities they serve. We need to ensure they are agile enough to respond to needs, and funded to achieve outcomes. We will align integrated Māori health contracts with Ngā Painga Hauora (the Auckland-Waitematā DHBs Health Outcomes framework), which includes: • Ensuring all Māori health providers have integrated contracts to allow for holistic models of care • Work with Māori health providers to reorient services to be better aligned with the needs in their community • Implement a sustainability process with Māori health providers	 Q1 Q4 Q4
Whakamaua Action 5.6 Work across the Northern Region to review the value of existing services to tāngata whaikaha and their whānau. In the first year, this review will focus on children's disability health services provided by DHBs to understand how responsive their model of care is to their patients and their whānau. This will include: • Refining data being recorded and reported by disability services for equity • Linkages with Māori health and whānau ora providers • Co-designing of new or enhanced services if necessary	 Q1 Q1 Q4
Whakamaua Action 8.5 Kōtui Hauora has the potential to provide oversight and guidance for major funding decisions within the Northern Region DHBs. This requires some critical pieces of work to occur: • Identify shared iwi and DHB priorities to focus resource and attention • Establish equity focused targets aligned to these priorities • Provide actions for each of these targets • Allocate resources to achieving these targets	 Q4

Improving sustainability

As New Zealand's population continues to grow and age, with more complex health needs, an enhanced focus on improving sustainability is required. This includes clearly demonstrating how strategic and service planning, both immediate and medium term, are supporting improvements in system sustainability, including work initiated from/supported by dedicated sustainability funding. Consideration of sustainability objectives and actions includes how the DHB will work collectively with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost growth paths and deficit levels.

Short term focus 2021/22
Funding, analytics and production planning actions to support improved sustainability in 2021/22

Action	Milestone
Improvements to support improved sustainability in 2021/22 *Sustainability funding initiatives* We are committed to continuing the savings programme to deliver $39M savings in 2021/22 from the following areas: • productivity gains $15.8M • cost containment $16.1M • revenue $7.5M. We will continue to develop other initiatives to mitigate risks associated with the delivery of these savings plans. In addition to these planned savings, we have a number of areas of risk that may further compromise our ability to improve sustainability for the coming period; these include risks of Multi-Employer Employment Agreements being settled over agreed national parameters, any costs associated with ongoing industrial action, and further costs associated with COVID-19	Ongoing
National analytics We will continue to review the performance of our services, including benchmarking, productivity and assessing revenue versus costs to ensure that service levels align with funding made available and also to ensure that any funding/cost differentials are fully understood both at Auckland DHB and nationally. Any potential savings initiatives from these reviews will be added to the financial sustainability programme	Ongoing
Production planning We will use our existing production planning processes to contribute to our Outpatient Performance Improvement programme, initially focusing on ESPI 2 performance and follow-up recovery trajectories to prioritise services for performance improvement resource support. Production planning will also be a key input into the refinement and scaling of the Surgical Integrated Operation Centre (SIOC), an operational management framework designed to maximise use and utilisation of operating theatre sessions. The SIOC model focuses on leading indicators of session use and utilisation, with the aim of identifying issues early, enabling mitigation, and subsequent review to uncover systemic issues that should be a target for continuous improvement. The key benefits to be realised are improved prioritisation resulting in reduced wait times and improved equity of access (difficult to quantify in dollars)	Ongoing

Medium term focus (three years)
COVID-19 learnings, sustainable system improvements and quantified actions to achieve breakeven

Action	Milestone
Innovative approaches from COVID-19 learnings We will continue to assess the key lessons learned from COVID-19 responses and impacts to inform our business continuity plans, resourcing strategies and service sustainability considerations, including supply chain. We will continue to improve our capturing of COVID-19-related costs to ensure that funding to offset costs is appropriately provided or that the impacts on the bottom-line are clearly understood	Ongoing
Sustainable system improvements over three years Review how education for nurses is undertaken and delivered within the DHB provider arm with the aim to achieve standardised best practice and reduce duplication by way of workforce and practice • Review current education frameworks • Plan and investigate best practice and options that will create future sustainability to changing education needs • Draft framework and model available for staff consultation • Implement approved education model	Q1 Q2 Q3 Q4

Medium term focus (three years) COVID-19 learnings, sustainable system improvements and quantified actions to achieve breakeven	
Action	**Milestone**
Quantified actions from the DHB's path to breakeven The short-term focus is on bringing Auckland DHB back to a breakeven position, focusing on revenue optimisation, reducing waste, increasing productivity and containing costs. The medium term focus will enhance collaboration with the Northern Region DHBs on service and capital planning to ensure affordability and sustainability of services, while understanding and realigning service provision to expectations of the Health Sector reforms. The sustainability savings included in 2021/22 are assumed to be sustained into the next 3 years.	Ongoing

Improving maternal, child and youth wellbeing

We actively work 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. For actions with a focus on ambulatory sensitive hospitalisations (ASH) in children aged 0-4 years, refer to the Maternity Care and Immunisation sections.

Maternity care Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity	
Action	**Milestone**
Maternity care as a result of COVID-19 learnings During COVID-19 outbreaks, some women preferred to give birth at home, and Home Birth Packs support LMCs with this service. We will support more LMCs to encourage home birth when appropriate. Messaging and practical supports reinforce this and may increase the number of planned home births	
• Promote Home Birth Packs to all midwives with access agreements	Q1
• Ensure at least 50 packs per quarter are available to LMCs	Q2
• Obtain feedback from midwives	Q3
• Ensure distribution of as many packs as required to meet LMC requirements	Q4
During COVID-19 outbreaks, advances were made with earlier discharge from maternity, where family support was in place. We plan to co-design a suite of support options to improve breast-feeding and parental confidence at home	
• Findings available	Q1
• Obtain Board approval to implement findings	Q2
• Develop tender documentation	Q3
• Tender process underway	Q4
Developing integrated service models to improve access *Social services* Use summer student audit results of current performance to increase % of referrals of pregnant women to Noho Āhuru – Healthy Homes and maximise interventions prior to birth or discharge from hospital	
• Disseminate results to referrers	Q1
• Increase the % of pregnant women referred (vs. those with an infant) from the 2019 baseline by 10%	Q3
Ultrasound Survey women postnatally regarding their primary maternity ultrasound experience to improve current understanding of the current state of the quality and quantity this service	
• Obtain approval for survey tool and method	Q1
• Provide final report on findings	Q3
Parenting education As Weaving Wānanga/Hapū Mama courses are effective in providing culturally acceptable information and support networks, we plan to improve access to this education for women and whānau by increasing the number of attendees and/or courses offered (EOA)	
• Review capacity in the courses to maximum participation	Ongoing
• Establish baseline participation and set improvement target	Q1
WCTO WCTO Coordinator to use NCHIP, a new data source, to engage more whānau with a WCTO provider of their choice (EOA)	
• 95% of Māori infants enrolled with a provider at 4 weeks	Q1

Maternity care
Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity

Action	Milestone
• 98% of all infants enrolled with a provider at 4 weeks	Q3
Screening programme Consider learnings from COVID-19 catch-up to increase equity of service delivery across Newborn Metabolic Screening and Newborn Hearing Screening (EOA) • Complete review • Implement action plan	 Q1 From Q3
Support a sustainable workforce through a positive culture Ensure an engaged midwifery workforce by implementing the national Midwifery Career Pathway • Implement the midwifery career pathway, ensuring role titles are consistent with national agreement • Implement respect workshops, review initial workshop with management and plan ongoing • Promote primary birthing options for women within Auckland DHB • Obtain staff feedback on respect workshop implementation and culture within the organisation	 Q2 Q2 Q2 Q4
Perinatal and Maternity Mortality Review Committee recommendations (focus on ASH in children) Develop and implement a plan to promote the incentivised pregnancy stop smoking service, including actions to increase referrals from primary care, Lead Maternity Carers and other health services (EOA) • Develop the plan with specific actions and timeframes • Provide regular clinics in at least two general practices with high numbers of Māori and Pacific pregnancies to support the whānau to become smokefree • Build partnerships with the ten LMCs with the highest number of Māori and Pacific women who smoke to increase their referrals • Encourage smokefree conversations by health services (e.g. Well Child Tamariki Ora providers) to increase referrals to Stop Smoking Services	 Q1 Q2 Q3 Q4
General Practices are the most common early connection point for confirmation of pregnancy, but some women are not well informed on how to access LMC care; GPs need to have high quality information available to support engagement between pregnant women and an LMC. Review and improve information on Health Pathways to increase Early Engagement with a LMC, subject to MoH data provision (EOA) • Establish Health Pathways working group with primary care • Review information • Update information • Earlier engagement of Māori, Pacific and quintile 5 (NZDep2018)	 Q1 Q2 Q3 Q4

Immunisation (focus on ASH in children)
Actions to improve and maintain high childhood immunisation rates

Action	Milestone
Outreach Immunisation Services (OIS) Work with the OIS provider to establish and open at least one drop-in clinic per DHB that is open during whānau-friendly hours to improve access for those unable to attend during existing clinic hours	Q3
Work with regional colleagues on timing of referrals to the OIS for Māori, Pacific and quintile 5 (NZDep2018) tamariki (EOA) • Review timing and process • Adapt referral processes, including testing a process for whānau PHO enrolment	 Q1 Q2
Maintaining immunisation coverage during the COVID-19 immunisation programme • Work with Māori and Pacific mobile providers and WCTO providers (including Plunket) to agree a protocol for delivering vaccinations to children (EOA) • Work with the COVID-19 immunisation roll-out team to ensure that workforce for delivery of childhood immunisation is protected	 Ongoing Ongoing
Immunisation engagement and communications plan Key community influencers, as trusted sources of information, are identified and engaged to encourage immunisation and reduce decline rates. We will work with our Māori and Pacific provider network to identify immunisation concerns and work in partnership on messages to address these concerns, including testing with their consumer groups (EOA)	Ongoing
The tone of public health messages is important; we received feedback that not all of our messages are encouraging. We plan to review the suite of automated messages (e.g. NIR and text to remind) to ensure	

Immunisation (focus on ASH in children) Actions to improve and maintain high childhood immunisation rates	
Action	**Milestone**
they are whānau-friendly and encourage access to services • Review NIR messages • Review primary care text messages • Update all whānau-directed messages	 Q1 Q2 Q4
Develop and trial a resource for new Māori and Pacific whānau that promotes the timing of childhood immunisation and Well Child tamariki ora checks (EOA) • Develop and test • Implement	 Q1 Q2
Māori influenza immunisation programme Continue to support Māori-led vaccination services that employ a holistic model to reach, educate and engage whānau/communities in their own care. Support includes NIR access and immunisation training to help sustain this service (EOA)	Ongoing
Focus on: increased immunisation at 2 years (CW05) Develop a nurse-led phone follow-up programme with whānau who decline immunisation to support informed choice. Increasing the opportunity for a conversation with an immunisation nurse to provide access to quality information may result in some whānau reconsidering vaccinations • Co-design concept with whānau • Trial and evaluate service	 Q2 Q4
Boost immunisation-positive messages on Māori/Pacific-targeted social media to reduce the impact of negative messages (EOA) • Identify or develop collateral • Release information to social media	 Q2 Q4
Prioritise referral of children overdue immunisations and not enrolled in a PHO to Noho Āhuru – Healthy Homes, including Māori and Pacific, for a social work assessment and facilitated engagement with primary care (EOA). We are seeking to ensure that the comprehensive supports provided by Noho Āhuru – Healthy Homes include offering immunisation along with other health interventions and engagement. Noho Āhuru can offer material supports to families (with a focus on young children) and is designed to work collaboratively, and in a way that is flexible and acceptable to families (e.g. with a home visit) • Co-design plan with Noho Ahuru and Immunisation Missed Event Services • Implement and review concept	 Q2 Q4
Improving immunisation coverage from infancy to five years of age Establish a joint Metro-Auckland Immunisation Operations Group, including PHOs, DHBs, Māori, Pacific, WCTO and LMC representatives, that will monitor coverage from birth to five years of age, streamline action plans and share learnings from the respective top performing GP clinics (EOA)	Q2
Contributory measures to support measurement of progress Timeliness of Māori immunisation measured at 6 and 18 months	85%
Declined immunisation (by ethnicity)	<3.0%

Youth health and wellbeing Actions to improve the health of our youth population	
Action	**Milestone**
Improve the health and wellbeing of priority youth populations Establish routine catch-up vaccination programme for Year 9 students alongside HEADDSSS. This additional vaccination opportunity will identify and vaccinate under-immunised, particularly Māori and Pacific, students who have missed out or are new to New Zealand (EOA) • All SBHS have NIR results for Year 9 students • ≥50% of students identified as unimmunised are fully vaccinated	 Q1 Q4
SBHS quality improvement Research demonstrated that YouthCHAT was more effective at eliciting some information from students and its use should be optimised, and barriers to its use be removed to improve AOD screening quality • Obtain baseline data • All schools to review the use of YouthCHAT as a routine part of HEADDSSS and use YouthCHAT alongside ≥80% of HEADDSSS assessments	 Q2 Q4

Youth health and wellbeing Actions to improve the health of our youth population	
Action	**Milestone**
Telehealth Build capacity for virtual appointments during school holidays for ESBHS students who otherwise may miss out on healthcare	
• Agree the approach with nursing teams	Q1
• Virtual appointments over the holidays are in place	Q3

Family violence and sexual violence Actions to reduce family violence and sexual violence in our communities	
Action	**Milestone**
Support COVID-19 recovery/embed learnings With school attendance disrupted, and some households experiencing the challenges with maintaining privacy of virtual sessions, discussions and education regarding sensitive issues was reduced, resulting in variable application of both screening and education within the ESBHS. This was a particular risk for Māori and Pacific households (EOA)	
• Review the delivery of Sexual Violence/Consent and Relationship Education by School Based secondary school nursing team	Q2
• Results (and training, if required) disseminated to all SBHS nurses, GPs and guidance counsellors	Q4
Evidence-based equity actions Core elements of achieving equity for Māori include training for health professionals to screen for family violence, and better linked services to ensure appropriate referrals are made once detected (EOA)	
• Ensure family violence training is available for staff of Māori health providers	Q1
• Establish a working group, or connect with existing groups, of stakeholders to focus on improving links between Māori health providers, iwi and providers the offer family violence programmes	Q2
• Review all relevant existing programmes to determine if family violence and sexual violence education, screening, and workforce development is required, and roll out recommendations of this review	Q4
Family violence literature suggests that immersive cultural and clinical services that deal with the perpetrator, victims and wider whānau are critically important for stopping violence within the home. Across Auckland and Waitematā DHBs, there is currently no kaupapa Māori family violence service for whānau (EOA)	
• Review existing family violence services across the two districts	Q1
• Recommend an agreed service model to the Auckland and Waitematā DHBs Boards and Kōtui Hauora for support and implementation	Q3
• Implement a kaupapa Māori family violence services for Auckland and Waitematā DHBs	Q4
Work with Pacific providers to identify any family violence and sexual violence training needs to support them to deliver services (EOA)	Ongoing

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, especially in response to the impacts of COVID-19 and its impacts on people's wellbeing. 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.

Improving mental wellbeing 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 and responding to the impacts of COVID-19	
Action	**Milestone**
Psychosocial response to and recovery from COVID-19 Use telehealth where clinically indicated across all DHB mental health services, with ongoing socialisation and promotion of this option to all staff, service users and whānau to improve the ability of tangata whai i te ora to engage with services in a way that supports access and choice, during and outside of COVID-19	Q4

Improving mental wellbeing 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 and responding to the impacts of COVID-19	
Action	**Milestone**
outbreaks (EOA). Achieve a relative 5% increase in uptake of telehealth over non-lockdown baseline (1.80% in Mar-May 2021; target is 1.89%)	
Support flow and service user/whānau engagement through virtual engagement (Acute Flow Project) to support engagement for tangata whai i te ora and their whānau with a focus on understanding what assists and prevents virtual engagement for Māori, Pacific, young people and others (EOA). Socialise virtual engagement as an option through collateral in our community services to encourage the use of telehealth	Q4
Integration of primary with secondary services Support GPs to access advice and support from psychiatrists in managing tangata whai i teo ora presenting to primary mental health care (EOA) by developing and implementing an SMO/GP phone line • Launch the GP phone line • Review efficacy and GP satisfaction	 Q1 Q4
Evidence-based equity actions – Māori Address inequities by accelerating responses to Māori homeless for tangata whai i te ora with severe mental health issues and complex needs (EOA). Māori tangata whai I te ora that meet the scope of this project are identified and engaged as part of the co-design process • Prioritise Māori inpatient service users in the Homeless/Transitional Housing Project	 Q4
Support the Directorate to address inequities in terms of access to services for Māori (EOA). All people leaders to engage in Te Tiriti training • Improve data use to better understand Māori access to services • Review existing data sources, with a further review of this information to identify key priorities	 Q4 Q2
Evidence-based equity actions – Pacific Address inequities in physical health outcomes in Pacific people with mental health issues (EOA). Increase to 25% of Equally Well service user in Lotofale having metabolic screening offered in line with the clinical pathway by January 2022 (baseline is 0%; this is a new programme) • Embed Equally Well practices and programmes in Lotofale	 Q4
Follow-up within 7 days post-discharge from an inpatient mental health unit (MH07) Evaluate the pilot NGO partner role embedded in the adult inpatient unit to ensure supports are in place and ongoing at discharge • Establish RBA • Measure and define • Decision whether to continue the pilot • Review and report on findings	 Q1 Q2 Q3 Q4
Monitor and follow-up all breaches of follow-up within 7 days post discharge in MHSOP • Establish process to capture and share data • Review number of breaches and identify service improvement • Review and revise processes • Evaluate improvement	 Q1 Q2 Q3 Q4
Contributory measures from the KPI programme Complete transition plans in 60% of children and young people Complete discharge plans in 80% of adults	 60% 80%
Total clients discharged from mental health and addiction adult inpatient services that are followed up within 7 days, by total, Māori and Pacific population	90%

Improving wellbeing through prevention

Our foremost priority is responding to COVID-19 as a public health emergency and global pandemic. We will focus on working with the Ministry to ensure our DHB/Auckland Regional Public Health Service to design and implement a national public health response where we will more effectively share limited resources, avoid duplication and increase the agility with which we mount a surge response anywhere in the motu and/or address future challenges.

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As our 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 identifying and treating health concerns early in life and in the life of disease progression.

Communicable diseases
Actions to advance communicable diseases control work, particularly implementation of the COVID-19 elimination strategy

Action	Milestone
Support COVID-19 recovery/embed learnings Maintain outbreak response capability for COVID-19 in the areas of prevention, preparedness and response, which is fundamental to New Zealand's public health response to the global COVID-19 pandemic	Ongoing
Transition Pae Ora Māori and Pacific response models, including makaaki services, from the COVID-19 Response Unit to the wider Auckland Regional Public Health Service (ARPHS) response, which transfers learnings into ARPHS service delivery and deepen the cultural appropriateness of responses to communicable disease events (EOA)	Q4
Core functions ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable disease • public health management of cases of communicable disease and their contacts • enquiries from medical practitioners, the public and others about suspected communicable disease of public health concern These actions help to ensure that the population of Tāmaki Makaurau is protected from notifiable infectious diseases	As required

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

Action	Milestone
As part of the Carbon Neutral Government Programme to reduce emissions: • Set emission reduction targets for 2025 and 2030	Q4
To transition to electric vehicles as per the government procurement rules: • Conduct a fleet optimisation study to review electric vehicle type, range and transition phase • Develop a plan to transition existing internal combustion engine fleet to electric vehicles	Q2 Q4
Ensure Māori representation on the sustainability steering group to align with Māori values of manaakitanga (respect and care for others) and kaitiakitanga (active guardianship) over the environment to preserve Māori culture and their health (EOA) • Engage to canvass ideas and actions that have a direct impact on equity outcomes • Develop an implementation plan for one recommendation to promote sustainability with an equity focus for Māori	Q2 Q4
Engage with our Pacific Health Gains team on equity/environmental actions to help develop a pathway for learning opportunities aligned to Pacific values and health outcomes (EOA) • Engage to canvass ideas and actions that have a direct impact on equity outcomes • Develop an implementation plan for one recommendation to promote sustainability with an equity focus for Pacific	Q2 Q4

Antimicrobial Resistance (AMR)
Actions to improve equity in outcomes and patient experience

Action	Milestone
Support COVID-19 recovery/embed learnings Support ARC facilities to maintain preparedness to effectively respond to COVID-19 (and other infectious disease) outbreaks through the work plan set by the Northern Region COVID-19 ARC Outbreak Steering Group and the associated Operations Working Group and Clinical and Public Health Working Group	Ongoing
Continue to participate in the Northern Region Laboratory COVID-19 Testing Network (Labs Regional COVID-19 Planning) to deliver an efficient and accurate testing service	Ongoing
Managing the threat of AMR Review the Auckland DHB MRO policy in response to the findings from the audit of adherence to the MRO screening policy	Q2
Advancing AMR management *Primary care* Implement an education plan to support improved antimicrobial prescribing, with focus on Māori and other high need populations (EOA)	Ongoing
Age-related residential care services 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
Hospital services Complete the development of an electronic form to capture in an individual patient's medical record the outcome of a 'penicillin allergy alert' review and use this form to inform their primary care provider	Q2

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

Action	Milestone
Compliance and enforcement activities • Undertake interim compliance and enforcement activities relating to the Health Act 1956, while drinking water functions are transferred to Taumata Arowai, the new national drinking water regulator. This will ensure there are no gaps in enforcement during the transition to the new authority • Transfer drinking water supplies data and regulatory function to Taumata Arowai • Report against the performance measures contained in the Drinking Water planning and reporting template 2021/22 (Vital Few Report)	As required Ongoing until the transfer Q2, Q4
Highlight non-compliant supplies, or water supplies that predominantly serve Māori or Pacific, or those which potentially pose public a health risk, to Taumata Arowai (EOA)	Ongoing

Environmental and Border Health
Actions to ensure compliance with environmental and border health legislation

Action	Milestone
Support COVID-19 recovery/embed learnings In the event of a suspected, probable or confirmed COVID-19 case on board of a ship in New Zealand waters, liaise with maritime stakeholders, NZ Customs, Ministry for Primary Industries, ship agents, Ports of Auckland/Harbour Control for the prevention of secondary spread of the infection into the community	Ongoing
Continue to focus on the border worker and household contacts of border worker cohorts of the COVID-19 vaccination roll-out, including priority populations (Māori and Pacific) within those cohorts with input from external partners (e.g. employers, iwi) in the most appropriate ways (including communication, venues) to maximise cohort engagement and vaccine uptake (EOA)	Ongoing
Manage extension of the Northern Region's vaccination programme to include priority groups (as indicated by the Ministry) within the general population through co-developed strategies with Māori and Pacific community partners, venue selection and communication activities (EOA)	Ongoing
Evidence-based equity actions Partner with Ngāti Whātua to identify common priority areas of environmental health activity and develop an equitable action plan to address concerns. This will include an agreed communications	Q2, Q4

Environmental and Border Health

Actions to ensure compliance with environmental and border health legislation

Action	Milestone
pathway, sharing of information and timely response to emerging issues (EOA)	
To ensure culturally appropriate community engagement with Pacific communities (EOA): • Develop and implement a Pacific model for enteric disease investigation (DI) • Deliver training to all DI staff on the new Pacific engagement model	 Q2 Q4
Compliance and enforcement activities Within the funding provided, undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, by delivering on the activities and reporting on the performance measures contained in the Environmental Health planning and reporting 2021/22 template, across the three Metro Auckland DHBs. This is important to minimise the risks of adverse health to enable communities living in Tāmaki Makaurau to be free from environmental health hazards. Activities include: • Work with Auckland Council to provide public health advice on strategic long-term planning regarding urban development while ensuring ARPHS focus is aligned with mana whenua priorities within the ARPHS region • Provide Vital Few reports	Ongoing Ongoing Q2, Q4

Healthy food and drink environments

Actions to create supportive environments for healthy eating and healthy weight

Action	Milestone
Create support environments for healthy eating Continue to implement the National Healthy Food and Drink Policy for staff and visitors, targeting priority groups, including Māori and Pacific (EOA) • Engage and consult with unions and relevant stakeholders to move to water and unflavoured milk only policy • Remove the cold drinks currently under the 'orange' category of the policy and allow the sale of only bottled water, unflavoured mild and compliant smoothies ('green' category)	 Q2 Q4
Health Active Learning Support early childcare education centres to establish food and drink policies to encourage healthy nutrition behaviours in the early years of life: • Initial engagement with Auckland kindergarten association • Engage all kindergartens in the Auckland kindergarten Association (approximately 100 centres) in establishing a food and drink policy	 Q2 Q4

Smokefree 2025

Actions to advance progress towards the Smokefree 2025 goal

Action	Milestone
Support COVID-19 recovery/embed learnings Embed a new model in the provider arm to offer smoking cessation support via virtual, as well as face-to-face, meetings as a new way of working, to increase flexibility for clients to improve engagement in quit attempts • Embed model as BAU	 Q2
Improve stop smoking outcomes for Pacific Review the findings of the evaluation of the Pacific community smokefree pilot project and use the findings to procure future services to reach more Pacific smokers and support them to quit (EOA) • Agreement with evaluation provider in place • Evaluation received • Ongoing services revised and procured	 Q1 Q3 Q4
Reducing equity gap for Māori Review the findings of the evaluation of the Wāhine Māori community smokefree pilot project (in including young Māori women) and use the findings to procure future services to reach more Wāhine Māori smokers and support them to quit (EOA) • Agreement with evaluation provider in place	 Q1

Smokefree 2025 Actions to advance progress towards the Smokefree 2025 goal	
Action	**Milestone**
• Evaluation received • Ongoing services revised and procured	Q3 Q4
Compliance and enforcement activities Undertake compliance and enforcement activities relating to the Smokefree Environments and Regulated Products Act 1990 by delivering the activities and reporting on the performance measures contained in the Smokefree 2025 planning and reporting 2020/21 template (Vital Few Report). This work supports the 2025 Smokefree initiative in Tāmaki Makaurau and aims to reduce access and exposure to tobacco • Provide Vital Few reports	Ongoing Q2, Q4

Breast screening Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific	
Action	**Milestone**
Support COVID-19 response and recovery Work with provider to test whether prioritised appointment times for Māori and Pacific wāhine result in improved access (EOA). The measure is PV01, 70% breast screening coverage for women aged 45-69 years for Māori, Pacific, Asian and total population	Q4
Participation Share recommendations from the Find 500 Māori Women campaign and review the results (EOA) • Work with the project team, including providers, to identify the limitations and strengths of the approach • Work with Pacific stakeholders to consider whether learnings can be applied to the Pacific community • Embed identified strengths of the approach into engagement, recruitment and retention strategies for Māori and Pacific women	 Q1 Q1 Q4
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). The measure is PV01, 70% breast screening coverage for women aged 45-69 years for Māori, Pacific, Asian and total population	Q4

Cervical screening Provide equitable access to screening to reduce mortality and morbidity, particularly in Māori, Pacific and Asian women	
Action	**Milestone**
Improve coverage in Māori and Pacific Pilot and evaluate an incentive scheme for low income unscreened and overdue Māori and Pacific women to engage in cervical screening (EOA)	Q4
Reduce equity gap in screening Explore opportunities to promote screening uptake in collaboration with Māori and Pacific providers (EOA) • Complete plan with input from stakeholders • Collate learnings	 Q1 Q4
Improve equitable access to diagnostic and treatment colposcopies Work with colposcopy clinics, the register and SSS to understand any system improvement opportunities for any person with HG cytology who has no recorded histology at 6 months	Q1
Support COVID-19 recovery/embed learnings Share COVID-19 recovery learnings from NCSP with stakeholders to manage screening catch-up and prioritisation in case of future COVID-19 outbreaks	Q2

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

Action	Milestone
Evidence-based actions to reduce inequities in alcohol-related harm ARPHS to re-design its compliance processes to consult with Ngāti Whātua and Tainui on new bottle shop licence applications to give greater consideration and a stronger voice to Māori needs when assessing applications (EOA)	Q4
Establish regional advocacy group on alcohol harm minimisation	Q4
Following Board endorsement, ensure ongoing implementation of the DHB's Position Statement on 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 • Ensure equitable access to alcohol harm reduction services, especially in Māori communities who experience a significantly higher burden of alcohol-related health conditions (EOA)	Ongoing
Compliance and enforcement Undertake compliance and enforcement activities relating to the Sale and Supply of Alcohol Act 2012 to help reduce alcohol-related harm. This includes delivering on the activities and reporting on the performance measures contained in the Reducing Alcohol Related Harm planning and reporting 2021/22 template (Vital Few Report) • Assess all alcohol off licence applications received • Provide Vital Few reports	Ongoing Ongoing Q2, Q4

Sexual and reproductive health

Actions to advance sexual health services and sexual health promotion work

Action	Milestone
Support COVID-19 recovery/embed learnings Strengthen service capability to provide patients options. This enable careful triage management during changing COVID-19 alert levels to ensure continuity of care through telehealth and virtual channels • Clinko system (a patient self-booking system) in place • Streamline patient follow-up by offering virtual 15-minute follow-up consults for HIV PrEP	 Q2 Q4
Reducing inequities Review clinic locations in conjunction with community/local iwi representatives to ensure appropriate services are offered locally for Māori and Pacific (EOA) • Complete West Auckland review • Complete South and North Auckland reviews	 Q2 Q4
Refine metrics that provide outcome data for patient populations to improve our understanding of health outcome gaps, particularly for our Māori and Pacific patients (EOA) • Embed metrics as part of service operating model • Review metrics and complete clinical outcomes audit	 Q2 Q4
Implement point-of-care syphilis testing aimed at Māori and Pacific in high needs areas to increase case detection (EOA) • Define model • Implement model	 Q2 Q4

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

Action	Milestone
Support COVID-19 recovery/embed learnings ARPHS shares COVID-19 learnings with cross-sectoral organisations as appropriate • Report on information shared **Wider determinants of health** ARPHS works in partnership with other cross-sectoral organisations across the Auckland region to	 Q2, Q4

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	
Action	**Milestone**
support Health in All Policies to achieve equitable health outcomes (EOA), where resources and capacity allow • ARPHS leads the Healthy Auckland Together (HAT) coalition • ARPHS leads the Auckland Intersectoral Public Health Group (AIPHG) Working with key stakeholders (the AIPHG group), ARPHS aims to improve whole-of-government responsiveness to public health issues in Tāmaki Makaurau. The Healthy Auckland Together coalition aims to improve nutrition, increase physical activity and address obesity in Tāmaki Makaurau. ARPHS ensures that HAT and AIPHG membership includes Māori and Pacific representation	Q4 Quarterly
To share ARPHS knowledge and expertise on public health topics and to promote Health in All Policies, ARPHS contributes to relevant regional and national policy development process on wider social and economic determinants of health. An equity lens will be applied to all submissions through the use of the Heath Equity Assessment Tool (HEAT) to consider impacts on Māori and Pacific populations (EOA)	As required
ARPHS engages with the Metro Auckland DHBs on its newly developed Pacific Strategy. This in turn, will inform the development of the strategy's implementation plan. ARPHS' Pacific Strategy focus areas are community engagement, outbreak surveillance, Smokefree 2025, reducing alcohol harm and nutrition (EOA) • Engagement with Auckland DHB • Engagement with Counties Manukau and Waitematā DHBs	 Q1 Q2, Q3

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

New Zealanders are living longer but are spending more time in poor health. Therefore, we expect strong demand for health services in the community, our hospitals, and other healthcare 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	
Action (all are EOA)	**Milestone**
Support COVID-19 recovery/embed learnings The unregulated/community support/navigator workforce was critical to the agile models that Māori health providers and whānau ora employed in response to COVID-19. We will continue to work with the NRHCC to fund these roles and provide support to develop and train this workforce to take on more responsibility for their communities. We plan to: • Continue support for Kaimanaaki/Whānau navigator roles • Offer professional development opportunities to this workforce	 Q4 Q4
Work with Pasifika Futures, Pacific providers, communities and stakeholders to identify joint approaches to support Pacific recovery in Pacific communities (including vaccination roll-out), informed by learnings and insights from joint work on the Pacific COVID-19 response	Ongoing
Evidence-based equity actions Continue to provide a whānau ora response network of providers to support COVID-19 outbreaks, welfare support cases and networking among providers/teams	Ongoing
Establish an ongoing relationship with the Tamaki Pan-Pacific Network (driven/owned by Pacific community leaders and members) to better enable Auckland DHB to understand the needs of Pacific individuals, families and communities in Tamaki, and design and deliver services to address their identified needs • Establish relationship	 Q1
Continue to work with and support Healthy Village Action Zone stakeholders to deliver services to address their communities' identified needs	Ongoing

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 Actions that demonstrate delivery of the most important aspects of Ola Manuia	
Action (all are EOA)	**Milestone**
Support COVID-19 recovery/embed learnings *Real-time data and contact tracing – inform actions, initiatives and policies* Continue to influence data collected, and analyse and share Pacific data to inform and enable actions, initiatives and policies (including COVID-19 vaccination roll-out) to reduce Pacific health inequities	Ongoing
Real-time data and contact tracing – culturally appropriate and effective contract tracing Continue linkage with Pacific contact tracing and case management team in ARPHS, and to share learnings	Ongoing
Communications for Pacific communities – health literacy and dissemination of public health messages Work with Cause Collective, Pacific providers and local Pacific community networks to identify ways to support and strengthen effective dissemination of culturally appropriate public messages for Pacific communities	Ongoing
Ongoing access to wrap-around services Continue to support the Fanau Ola integrated services to provide wraparound health and social services for Pacific families with complex needs and experiencing hardship, including due to the impact of COVID-19	Ongoing
Relationships with the Pacific health sector Refer to the Pacific COVID-19 action in Delivery of Whānau Ora, and the communication action above	
Ola Manuia health and disability system indicators *Support and grow our Pacific workforce* Increase support to our Pacific candiates through bespoke recruitment process, including prioritised recruitment, pre-interview support, post-interview check-in and support as required, and redirection to alternative roles	Ongoing
Develop cultural responsiveness of our services Trial Pacific Care Navigators to support Pacific patients through their Planned Care pathways to address inequities for Pacific patients and families • Complete evaluation of the trial and assessment of how learnings/findings can be used to support sustained cultural responsiveness of our services • Implement at least one review finding	 Q1 Q4

Care Capacity and Demand Management (CCDM) Actions for full implementation of CCDM for nursing and midwifery	
Action (all are EOA)	**Milestone**
Complete and/or maintain implementation of CCDM for nursing and midwifery in all units/wards Undertake annual CCDM FTE calculations into nursing, midwifery and mental health Directorates as per annual plan • Ensure that annual FTE calculations are on track and reported • Provide quarterly updates as required by the Ministry	 Quarterly Quarterly
Maintain permanent governance for CCDM for the organisation and for each ward/unit, including Directorate Focus Groups and Trendcare Governance • Meet, monitor and report to plan	 Quarterly
Use the Core Data Set to evaluate the effectiveness of CCDM in Auckland DHB, report and make improvements, as led by the Executive Council • Meet, monitor and report to plan	 Quarterly
Continue quality improvement activities in Variance Response Management led by a working group • Meet, monitor and report to plan	 Quarterly

Health outcomes for disabled people

Actions that demonstrate commitment to embed key learnings from the COVID-19 response and to improving outcomes for Māori and Pacific disabled people

Action (all are EOA)	Milestone
Support COVID-19 recovery/embed learnings	
Review internal and external websites and communications for accessibility	Q4
Evidence-based equity actions	
Co-design with an external agency and facilitate e-learning and face-to-face workshops for staff on Māori and Pacific disability and Māori and Pacific cultural perspective (EOA)	
• In place for Māori	Q2
• In place for Pacific	Q2
Actively work with external agencies to help facilitate job applications and opportunities for Māori and Pacific with a disability or access need (EOA)	
• Begin pilot for Māori	Q3
• Begin pilot for Pacific	Q3
Develop health needs assessment information for disabled people	Q4

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

Action	Milestone
Support COVID-19 recovery/embed learnings	
Ensure services have surge plans in place to protect Planned Care delivery from being affected by any future COVID-19 community response	Q1
Strategic priorities of the Three-Year Plan for Planned Care	
Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed	
Reduce inequitable waiting times to Planned Care treatment services for Māori and Pacific patients by reviewing the transport and accommodation barriers to accessing Planned Care for Māori, Pacific and other priority populations identified (EOA)	
• Complete review	Q2
• Implement at least one improvement initiative	Q3
Balance national consistency and the local context	
Review and align access criteria and clinical thresholds regionally by reviewing and rolling out the Auckland DHB Access Booking and Choice Policy to ensure it is aligned with national and equity guidelines (links to SS07)	
• Review policy and obtain approval	Q1
• Begin policy implementation across target services	Q2
• Report on compliance and benefit realisation	Q4
Support consumers to navigate their health journeys	
Implement an equity-focused approach to address inequalities in Planned Care Services by introducing Māori Care Navigation (Kaiārahi Nāhi) and Pacific Care Navigators to support changes to Planned Care pathways (EOA)	Q1
Optimise sector capacity and capability	
Redesign service to increase access and provide more timely care by reviewing the pathway for children requiring access to specialist Oral Health Services and implement a plan that makes better use of local and regional community and DHB capability and capacity	
• Develop new pathway	Q1
• Implement pathway	Q2
• Review new pathway outcomes	Q4
Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future	
Improve access and timeliness to diagnostics required to enable Planned Care by increasing the use of internal capacity to sustainably address waiting times for colonoscopy and meet increased demand for colonoscopy associated with the roll-out of the Bowel Screening Programme	
• Develop a Service Improvement Plan to ensure capacity to support ongoing internal demand	Q1
SS07 Planned Care Interventions (SS07)	
Extended the use of Patient-Focused Bookings across Auckland DHB services to improve access to	

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	
Action	**Milestone**
assessment and treatment services for Māori, Pacific and other priority populations (EOA) • In place with Starship • Business case to be signed off for Patient-Focused Booking to meet Q3 and Q4 plans • Expand to include some adult services • Review the benefits for service after 6 months	 Q1 Q2 Q3 Q4
Deploy alternative outpatient models of care contained within the Outpatient Toolkit to reduce unnecessary in-person on-site appointments and reduce DNA and cancellations • In place for two services • In place for two further services (total four) • Provide benefits realisation of outpatient toolkit to assess whether further opportunities exist • In place for six further services (total 10) and review benefits for services after 6 months	 Q1 Q2 Q3 Q4
Contributory measure Reduce DNA rates for all ethnicities (including Māori and Pacific) to <9%	 <9%
Reduce re-schedule rates for all ethnicities for services implementing Patient-Focused Bookings	<20%

Acute demand Actions to improve the management of patient flow and data in Emergency Departments	
Action	**Milestone**
Acute data capture Analyse volumes and workflow for common conditions using SNOMED data	 Q2
Streamline hospital pathways for patients to reduce length of stay and identify two pathways to improve quality of care	Q4
Acute demand *Adults* Implement the rapid referral pathway permanently within ED to reduce duplication of work for patients requiring admissions. Findings from a trial completed in 2020 demonstrated that 12% of ED patients could be rapidly referred within 30 minutes of arrival	 Q2
Review frequent presenters to ED and develop a plan to reduce presentations by 10% by ensuring further support is in place for these individuals	Q4
Improve acute care flow and support COVID-19 recovery/embed learnings *Children* Extend and refine the implementation of criteria-led discharge in Starship Surgical and Medical Services to facilitate discharges from the ward and improve patient flow • Pilot short stay surgical pathway • Implement criteria-led discharge in all short stay surgical areas • Complete roll-out	 Q1 Q3 Q4
Explore Starship community management options for respiratory patients to reduce unnecessary recurrent admissions • Identify pathways with the largest potential of positive impact on Māori and Pacific patients (EOA) • Design and implement pathways	 Q1 Q3
Adults Improve facilities to manage suspected COVID-19 patients • Finalise funding • Increase the number of negative pressure rooms and resuscitation bed capacity	 Q1 Q4
Equity in acute care *Children* Enable Starship services to better address inequity in pathways of care by developing service equity profiles utilising standardised methodology to identify and analyse data (including community and children's ED). Alongside improved visibility of inequities, extend the Clinical Excellence programme to actively support a quality improvement approach to address root causes of inequities. Focus on improving access to care through partnership with primary sector (EOA) • Review sustainability • Survey whānau and staff	 Q2 Q3

Acute demand Actions to improve the management of patient flow and data in Emergency Departments	
Action	**Milestone**
• Complete sustainable implementation	Q4
Adults Develop a specific plan, including a Māori support role, for ED to implement the Manaaki Mana strategy to reduce inequity for Māori, by providing more holistic care to patients and their whānau, improve discharge care planning and addressing institutional racism (EOA)	
• Develop plan	Q2
• Implement plan	Q4
Reduce delays to admission to the inpatient Psychiatric Unit by reducing length of stay through the design and implementation of supported intermediate care	Q4

Rural health Actions to plan and provide for the health needs of our rural population	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Continue to support COVID-19 response and recovery, including roll-out of the COVID-19 vaccination programme in rural areas	Ongoing
Evidence-based equity actions Continue to implement the Rural Ferinject and Rural Point of Care Testing Programmes, with a focus on Māori and Pacific populations (EOA)	Ongoing

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022 Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Support and facilitate the COVID-19 vaccine roll out to Aged Residential Care (ARC) and Home and Community Support Service (HCSS) providers	Ongoing
Support ARC and HCSS providers to maintain preparedness to effectively respond to COVID-19 (and other infectious disease) outbreaks	Ongoing
Emerging frailty in community and primary care settings, with a focus on Māori and Pacific Implement a standardised assessment tool from the InterRAI suite across Community Services to offer a longitudinal record of patient information within one electronic tool (inpatient rehabilitation, community (ACC), ARC sector). This will provide enhanced insight into areas of inequity and opportunities for improvement (EOA)	Q4
Dementia services Implement the new model of dementia care (to be developed in 2020/21) or components as relevant; this is dependent on funding and system capacity	Q4
Early supported discharge services and community-based support and restorative services, with an equity focus Implement a single point of entry for all hospital admission avoidance and early supported discharge (ESD) pathways to facilitate streamlining of patient entry into community services and an MDT approach to patient care	Q3
Implement a broadened 'Acute Frailty' pathway within the Reablement Services, which supports continuity of care, enhances whānau engagement and maximizes the use of ESD pathways. A focus of this pathway supports complex discharge navigation for priority populations (EOA)	Q1

Health quality and safety (quality improvement) Actions to improve equity in outcomes and patient experience	
Action	**Milestone**
Improving quality Design and implement an integrated Quality, Safety and Risk Framework	
• Complete design work	Q1
• Implement framework across all directorates	Q4
Develop tools and resources to improve our clinical risk and safety capability	
• Online learning module	Q2
Implement clinical document improvement	
• Complete pilot in Cardiovascular Services	Aug 2021
• Roll-out to two further directorates	Q2
• Roll-out to one further directorate	Q3
• Roll-out to one further directorate	Q4
Spreading hand hygiene practice Implement the PPE safe system of use programme across all clinical delivery units	
• Develop programme content	Q1
• Roll-out programme	Q4
Undertake an inaugural WHO Hand Hygiene Self-Assessment Framework maturity audit	
• Undertake initial assessment	Q1
• Implement prioritised findings	Q3
Improving equity – diabetes *Retinal screening data match* Undertake quarterly diabetic retinal screening data matches (PHO and DHB data) to identify those at highest risk of developing diabetic eye disease (based on ethnicity and diabetes control) and proactively working with the PHOs/primary care to refer people in, starting with those at highest risk (EOA)	
• 40% of the highest risk patients (identified as at June 2021) are referred, accepted and screened	Q4
Improving consumer engagement Progress the consumer experience work plan	
• Develop a single consumer experience team	Jul 2021
• Develop standardised reporting for the Consumer Experiences Council	Q1
Integrate the quality and safety marker implementation and reporting for consumer engagement into the Consumer Experiences Council work plan	
• Complete the second upload to HQSC	Oct 2021
• Use findings and report to aid communications throughout Auckland DHB	Ongoing

Te Aho o Te Kahu – Cancer Control Agency Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment	
Action	**Milestone**
Impact of COVID-19 resurgence Monitor access to CT, Planned Care and cancer treatments on a monthly basis, in the event of COVID-19 resurgence, noting impacts on Māori and Pacific people and other vulnerable groups, and incorporating remedial activities within service planning (EOA)	As required
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi DHBs delivering SACT to undertake quality improvement work in response to the implementation and reporting of the nationally agreed SACT NZ treatment regimens (national collection) for Medical Oncology and Malignant Haematology • Develop and implement regional electronic prescribing to enable full reporting of SACT data into national systems	Update quarterly
Auckland DHB will work with Te Aho o Te Kahu to plan and implement the adoption of the cancer-related Health Information Standards Organisation (HISO) standards, to be issued via Data and Digital • Adopt the HISO and ACT-NOW standards when published, specifically within the Regional Oncology Electronic Service (ROES) project for regional prescribing • Commence a review of the Auckland DHB-hosted MDMs against the HISO: 10038.4:2021 Cancer Multidisciplinary Meeting Data Standards to determine and implement any necessary updates	Update quarterly Q3
Work with Te Aho o Te Kahu Regional Hubs to develop a 5-year regional Radiation Oncology service plan	Update

Te Aho o Te Kahu – Cancer Control Agency Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment	
Action	**Milestone**
that ensures that the model of service is fit for purpose to meet the current and future needs of the region that they provide services to • With regional DHB partners, implement the agreed Radiation Therapy Regional Plan 2020-2030 • Continue the planned linear accelerator replacement programme, consistent with the Auckland DHB capital programme • Support outreach services for satellite LINAC business case: continue to co-develop Northland DHB linear accelerator business case (expected delivery date to be confirmed)	quarterly
Continue the planned linear accelerator replacement programme, consistent with the Auckland DHB capital programme	Update quarterly
Support for outreach services for satellite LINAC business case: continue to co-develop Northland DHB linear accelerator	Update quarterly
New Zealanders experience equitable cancer outcomes – He taurite ngā huanga Participate in Te Aho o Te Kahu travel and accommodation project activity, once agreed	Update quarterly
Support the national work programme for the delivery of local community-based Māori Hui in partnership with Te Aho o Te Kahu. From this engagement, DHBs can facilitate locally driven community-based initiatives with cancer patients and their whānau to drive service improvements • Te Pūriri o Te Ora (Regional Cancer and Blood Service), led by Pou Ārahi, to work with Te Aho o Te Kahu to deliver against outputs agreed through engagement process • Map lung pathway and identify focus areas where Māori and Pacific people experience inequitable access, determine means to rectify within services	Update quarterly
New Zealanders have fewer cancers – He iti iho te mate pukupuku Work with services to provide information to patients/whānau consistent with the Smokefree 2025, Reducing Alcohol Related Harm, Healthy Food and Environments, Long-Term Conditions, Cross-Sectoral Collaboration, Breast Screening and Cervical Screening sections. Examples include smoking cessation advice provided within clinical and support services (refer to the Smokefree 2025 section for activities focused on improving smoking cessation for Pacific and wāhine Māori)	
New Zealanders have better cancer survival, supportive care and end-of-life care, He hiki ake i te o ranga Develop/update an Auckland DHB Bowel Cancer Service Improvement Plan, including support for Māori/Pacific patients and enhanced recovery	Update quarterly
Develop an Auckland DHB Lung Cancer Service Improvement Plan, following publication of the QPI report	Q3
Develop an Auckland DHB Prostate Cancer Service Improvement Plan, following publication of the QPI report	Q3
Continue to meet FCT targets and continue to engage with Regional FCT group to ensure cross-DHB issues are managed	Update Q2, Q4
Regional Service/Pou Ārahi to work with National Hauora Coalition and Tongan Health Society on mahi, including the integration of care into the community via shared outreach clinics encompassing the continuum of cancer care from diagnosis to palliation, and Auckland DHB activity, including Service Improvement Plans (EOA)	Update Q2, Q4
FCT data quality • Continue to monitor FCT data accuracy • Update our in-house reports to further specify the 31-day target and its breach reasons	Ongoing Sep 2021

Bowel screening and colonoscopy wait times

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

Action	Milestone
Support COVID-19 recovery/embed learnings Review pilot of pre-assessment nurses and implement a permanent solution to ensure 80% of colonoscopy patients are engaged by a nurse prior to their procedure (to reduce DNA rates and improve engagement with at-risk populations)	Q2
Establish a stable, sustainable scheduling service to maximise the capacity of the gastroenterology service and achieve compliance measures for colonoscopy	Q4
Complete Global Rating Scale Gastroenterology audit and implement relevant action plans	Q4
Participation rates (focus on equity) Plan and deliver three multi-media communications campaigns designed to reach priority populations - incorporating social media, radio and print strategies and supported by health promotion activities in Māori and Pacific communities (EOA) • First campaign • Second campaign • Third campaign	 Q1 Q2 May 2022
Participation rates (overall population) Maintain a programme of community awareness raising and health promotion designed to maximise participation in the overall population and to provide a participation benchmark for the first cycle of the programme	Ongoing
Achievement of bowel screening indicator 306 Liaise with the symptomatic gastroenterology service to ensure that the number of screening colonoscopy sessions available is sufficient to ensure that indicator #306 is achieved	Ongoing
Support bowel screening nurses to ensure that data relating to the first offered appointment is correctly entered into the Register	Ongoing

Health workforce

Actions to support and improve the skills, flexibility, mobility and diversity of our staff members, and improve our organisational health and wellbeing

Action	Milestone
COVID-19 learnings Developing additional trained vaccinators to support the COVID-19 vaccine roll-out in 2021, including reviewing the use of non-nursing/non-regulated workforce to support the vaccine programme	Q1
Continue to train and refresh people with contact tracing skills to support public health in the event of a community resurgence of COVID-19 in Auckland, including the use of people from across the multi-disciplinary team	Ongoing
Engagement with unions As part of reviewing the use of non-nursing/non-regulated workforce required to support the vaccine programme, engage with unions at an early stage to: • Create a flexible fixed-term workforce, collaborating with unions on how to set up the workforce, including training • Identify ways that the current regulated workforce can be used across the vaccine sites by allowing flexibility in their current hours of work, where possible	 Q1 Q1
For front-line employees who choose not to be vaccinated: • Create a strategy to enable their redeployment to other services • Engage with unions on this issue and outline a strategy • Work collaboratively with unions to identify other services where staff can be redeployed to	 Q1-2 Q1-2 Q2-3
Diversity of representation in leadership Implement the Māori Workforce Leadership Development programme to support leadership representation across all levels of the organisation	Q4
Cultural competence and safety Key in Te Toka Tumai 'Pūmanawa Tāngata' is a domain of work that ensures we enable our workforce to effectively deliver to He Korowai Oranga, Whakamaua and Te Toka Tumai strategy to 2023. This work serves to build our workforce capability in order to deliver the on Whakamaua. Key actions are: • Design and implement online hub 'Building Capability for Pae Ora) available to all staff within Ko Awatea Learn • Deliver Provider Directors 'Leading for Equity' programme to support and enable our directorate	 Q1 Q3

Health workforce

Actions to support and improve the skills, flexibility, mobility and diversity of our staff members, and improve our organisational health and wellbeing

Action	Milestone
leaders to deliver against the strategic pillars	
• Design and implement Whātuatanga module with Ngāti Whātua – available to all workforce	Q3
Sustainability, health, safety and wellbeing Auckland DHB is committed to providing a safe environment for our people, patients, visitors and contractors. This includes supporting mentally healthy work. Refer to Section 4, Health and safety and healthy workplaces for further information. In 2021/22, we will:	
• Develop a capability framework to ensure our health and safety workforce is matched with the needs of our people and organisation	Q2
• Identify the appropriate supports for key scenarios and ensure our leaders and workforce have access to tools and services at the right time	Q4
• Revise and develop updated health and safety training plans for our people	Q3
• Incorporate health and safety specifications into our contractor/supplier agreements that effectively support our approach to managing risk and overlapping duties	Q3

Data and digital enablement

Actions to improve our information technology systems to better support healthcare delivery to our population, including supporting COVID-19 recovery

Action	Milestone
Support COVID-19 recovery/embed learnings Develop e-outcome forms to electronically capture the outcome of outpatient events to support remote working, non-contact visits, telehealth and in person events, and improve reliability and efficiency of throughput	
• Design forms	Q3
• Commence build integration	Q4
Address and resolve significant initiatives delayed by COVID-19 Develop data presentation dashboards to support the surgical integrated operations centre	
• Scope requirements	Q1
• Design and build dashboards	Q2
• Implement	Q4
Improve digital inclusion in health services Replace the current multi-step manual process through building and integrating Zoom booking into the patient management system to allow seamless and integrated scheduling of telehealth appointments to increase the use of video telehealth uptake	
• Design and build integration	Q2
• Rollout to services	Q4
Improve equity of access to health services via digitally enabled means Implement patient online booking for ambulatory appointments to allow patients flexibility to choose times that suit them, thus improving access to health services	
• Scope requirements	Q2
• Commence design	Q4

Implementing the New Zealand Health Research Strategy Actions that demonstrate a commitment to support the implementation of the New Zealand Health Research Strategy	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Within the funding available, ARPHS will: • increase research and evaluation capacity and capability across the organisation • strengthen its research and evaluation policies and procedures; these reflect Māori mātauranga and guidance and Pacific knowledge and guidance (EOA)	 Q4 Q4
Time-critical COVID-19 research to have risk management and institutional review via an expedited process to position Auckland DHB to participate in crucial COVID-19 research and uptake learnings from that work • Develop process SOP • Implement improvements	 Q1 From Q2
Building DHB capacity and capability to enhance research and innovation Establish a 2021/2022 work plan for the national DHB research officers' collaboration (ROMA) to allow knowledge sharing and support for smaller DHBs	Q2
Create knowledge resources and roadmaps to enhance DHB researchers' capability to collaborate cross-regionally and nationally to improve recruitment to clinical trials	Q4
Working with regional research networks to support research and innovation staff Involve Māori at the earliest stage (and throughout) to enhance potential for the research to achieve Māori health advancement (EOA), and coordinate and complete Māori consultation to guide proposal development for funding bids to Health Research Council (HRC)	Q2
We aim to grow our Māori workforce as part of our Board strategy to improve equity and bring Te Tiriti to the fore (EOA). We plan to establish a priority-setting framework for specialties to identify and encourage research that will have maximal impact on their Auckland DHB strategic goals • Complete consultation • Complete framework	 Q2 Q4
Building a supportive environment for clinical staff to engage in research and innovation Establish partnership between central research office and Awa Manawa (Auckland DHB Innovation) so that DHB staff will have access to a wraparound service to optimise their participation across the research and innovation spectrum • Begin to pilot the online engagement platform	 Q3
Providing staff with professional development opportunities Nurture promising individuals through the HRC programme to become future research leaders in their specialties • Support ≥2 Auckland DHB applications for HRC Career Development Awards	 Q1
Publish a comprehensive calendar of national and international health research funding and training opportunities so that staff can identify and target the most relevant opportunities in their annual plans	Q2

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 the use of illness-preventing behaviours and treatments, 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 integrate across health disciplines and facilities, thereby improving health outcomes and serving all people equitably.

Primary care Actions to strengthen our district alliances, address equity gaps and improve access to primary care services	
Action	**Milestone**
Support COVID-19 recovery/embed learnings Support continued implementation and use of telehealth in primary care • The Alliance to review use • The Alliance to develop an improvement plan	 Q2 Q4
Evidence-based equity actions – Māori and Pacific Support the roll-out of the COVID-19 vaccination programme, with a focus on Māori and Pacific coverage	Ongoing

Pharmacy

Actions to support the optimisation of pharmacy services

Action	Milestone
Support COVID-19 recovery/embed learnings Continue to support the COVID-19 response and recovery, including the roll-out of the COVID-19 vaccination programme	Ongoing
• Commission up to approximately 100 pharmacy providers to support the delivery of the COVID-19 vaccination programme across Metro Auckland DHBs	Q2
Improving influenza vaccination rates in priority populations Support pharmacies to increase coverage rates of Māori, Pacific and target populations who are eligible for influenza vaccination (EOA)	
• Identify key vaccinating pharmacy providers with the highest number of Māori, Pacific and target populations	Q3
• Collect baseline data (including ethnicity) to monitor coverage over time. Use the data to support pharmacies to promote targeted approach to immunise eligible Māori and Pacific populations in their communities	Q4
Integrated community pharmacy services Sustain the Safety in Practice Programme 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 (note this programme is currently postponed while we divert resources to support the COVID-19 vaccination programme; tentative re-start date is Jan 2022)	Ongoing

Reconfiguration of the National Air Ambulance Service Project – Phase Two

Actions that demonstrate active participation in the national two-phased 10-year reconfiguration of the national air ambulance service

Action	Milestone
The DHB is 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 implement Phase II. 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, including identifying appropriate nominees, participating in meetings and workshops, provision of information in a timely manner • supports the development of a robust national process to develop a national tasking service	Ongoing

Long-term conditions

Actions to strengthen public health promotion on preventing and managing long term conditions, including equitable service access

Action	Milestone
Improving prevention through evidence-based nutritional and physical activity advice provided to at-risk population groups In addition to existing indoor green prescription (GRx) programmes, connect people from high deprivation areas to free outdoor, nature-based, physical activity opportunities (e.g. maunga, parks, beaches), including sites of cultural significance to Māori (EOA). Our GRx providers routinely survey participants for feedback to help develop the most effective services and activities	
• Deliver ≥10 nature-based sessions each quarter	Q2, Q3
Strengthening identification, intervention and recall of people with high and moderate risk Improving coding of ethnicities at level 4 for screening newly eligible population in line with the 2018 MoH CVD Risk Assessment and Management Primary Care guidelines.	
• 70% of all newly eligible population (Māori, Pacific and South Asian men 30-34 years old and women 40-44 years old) requiring a CVD risk assessment will be able to be identified	Q4
Management of people with long-term conditions The redesign of diabetes retinal screening services is driven by a strong service user voice, including Māori and Pacific people living with diabetes. The new service will support improved retinal screening coverage and equity of coverage through multiple access points in the community and an outreach service (EOA)	

Long-term conditions Actions to strengthen public health promotion on preventing and managing long term conditions, including equitable service access	
Action	**Milestone**
• Complete the procurement process for a new model of care for diabetic retinal screening	Q4
Hepatitis C • Work with MoH to undertake a datamatch to identify people with known hepatitis C and re-offer treatment (follow-up action from previous datamatch in 2018) • Under the Māori Health Pipeline, establish a hepatitis C team to re-offer treatment to those identified, on behalf of the Northern region, with a focus on elimination for Māori first	Q1 Q2
Adult ASH (SS05) Refer to actions in the Complex Conditions and Frail Elderly and Primary Options for Acute Care (POAC) priority areas in Section 7 of the 2021/22 Metro Auckland System Level Measures Improvement Plan	

Financial Performance Summary

Statement of Comprehensive Income	2019/20 Audited Actual $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Funding						
Government & Crown Agency Sourced	1,688,523	1,812,322	1,935,831	2,022,421	2,062,328	2,103,027
Non-Government & Crown Agency Sourced	106,934	104,775	101,508	101,508	101,508	101,508
IDFs & Inter-DHB Sourced	701,179	762,699	812,064	827,937	844,129	860,643
Total Funding	**2,496,636**	**2,679,796**	**2,849,403**	**2,951,867**	**3,007,965**	**3,065,179**
Expenditure						
Personnel Costs	1,211,109	1,265,567	1,307,405	1,332,766	1,359,421	1,386,609
Outsourced Costs	155,094	181,283	162,435	164,989	168,289	171,655
Clinical Supplies Costs	312,320	333,615	349,726	353,440	358,750	364,139
Infrastructure and Non-Clinical Supplies Costs	219,566	230,551	217,497	221,532	223,982	226,502
Payments to Providers	599,022	660,241	768,473	797,811	813,768	830,043
IDF Outflows	103,143	104,768	116,867	121,329	123,755	126,230
Total Expenditure	**2,600,253**	**2,776,025**	**2,922,403**	**2,991,867**	**3,047,965**	**3,105,179**
Share of associate joint venture surplus/(deficit)	**(150)**	**-**	**-**	**-**	**-**	**-**
Net Surplus/(Deficit)	**(103,767)**	**(96,229)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**
Other comprehensive income						
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
Total Comprehensive Income/(Deficit)	**(103,767)**	**(51,393)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**

The net surplus/(deficits) shown above comprises deficits from an extraordinary item for the Holidays Act liability, unfunded COVID-19 impacts, and underlying business as usual operations as summarised in the table below.

Statement of Comprehensive Income	2019/20 Audited Actual $000	2020/21 Forecast $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Holidays Act Liability increase	(60,768)	(39,731)	(40,000)	(40,000)	(40,000)	(40,000)
Business as usual	(16,657)	(41,780)	(33,000)	-	-	-
Unfunded COVID-19 Impacts	(26,342)	(14,718)	-	-	-	-

Statement of Service Performance (four-year plan)

Prospective summary of revenues and expenses by output class	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Early detection				
Total revenue	518,044	536,673	546,872	557,274
Total expenditure	516,937	529,224	539,147	549,268
Net surplus/(deficit)	**1,107**	**7,448**	**7,724**	**8,006**
Rehabilitation and support				
Total revenue	288,657	299,037	304,720	310,516
Total expenditure	303,037	310,240	316,057	321,990
Net surplus/(deficit)	**(14,380)**	**(11,203)**	**(11,337)**	**(11,474)**
Prevention				
Total revenue	124,949	129,442	131,902	134,411
Total expenditure	137,458	140,725	143,364	146,055
Net surplus/(deficit)	**(12,509)**	**(11,283)**	**(11,462)**	**(11,644)**
Intensive assessment and treatment				
Total revenue	1,917,753	1,986,715	2,024,471	2,062,978
Total expenditure	1,964,971	2,011,678	2,049,397	2,087,867
Net surplus/(deficit)	**(47,218)**	**(24,962)**	**(24,925)**	**(24,888)**
Consolidated Auckland DHB				
Total revenue	2,849,403	2,951,867	3,007,965	3,065,179
Total expenditure	2,922,403	2,991,867	3,047,965	3,105,179
Net surplus/(deficit)	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**

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. Auckland DHB will manage its functions in a way that supports the intended direction and anticipated system change programme.

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 2021/22.

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 further action plans to be completed for implementation in 2021/22: • Oral health specialist services streamlining patient pathway, reducing wait times and review of service locations • Continuing review of complete oral health pathway for children, including Auckland Regional Dental Service • Sarcoma services. Continue streamlining patient pathway, review and consider implementation of alternative service locations • Vascular services. Streamlining patient pathway and implementation reconfiguration of regional services as per regional agreement	• Children and adolescents receive timely secondary level dental care closer to home • Sarcoma patients receive timely tertiary level services in the most appropriate setting • Patients receive timely secondary and tertiary level vascular services in the most appropriate setting and closer to home, where appropriate	Oral health - Regional and Local Sarcoma - Regional and National Vascular - Regional and Local
Expansion of Service	The Northern Region Chief Executive forum endorsed in Dec 2020 the recommendations from the High Users of Inpatient Services in the Northern Region report to invest from late 2020/21 across the region in: 1. a regional 10-bed intensive residential service (or equivalent packages of care) for older high users (age 55+ years); estimated cost is $1,656,690 per annum 2. an annual budget to finance 21 intensive packages of care for high users of inpatient services; estimated total cost is $3,780,000	Improved access to and delivery of services to increase responsiveness and flexibility, and better respond to client needs and reduce long-stays in inpatient units, which are not clinically indicated	Regional
Change in location and expansion of services	CADS Regional Medical Detox and Regional Social Detox service to co-locate at a new build in central Auckland (Mission Homeground), now expanded by an additional 5 beds	Service will be delivered within a purpose-built building; service will be located with other complementary services	Regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Potential change in model of service delivery	*Supra Regional Eating Disorder Service (EDS)* Midland DHBs originally withdrew from all elements of Supra Regional EDS except residential service, and the service adjusted capacity accordingly. Midlands DHBs previously signalled an intention to withdraw from the residential service over time; however, engagement with them confirmed we are the only provider of this service in New Zealand that can accommodate them. One Midland DHB 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. Hence there is an on-going need to consider a regional response to service delivery to be prepared for any potential future withdrawal by Midland DHBs	Auckland DHB service resized for the Northern Region population for all EDS, including residential services. Uncertainties regarding ongoing Midland DHBs population demand and 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 residential services	Supra Regional DHBs - Northern Region and Midland DHBs
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 in 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* Engage with maternity stakeholders to identify opportunities to improve equity of services	• Improve birthing options for local population • Promote 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	• Improve access to services • Improve 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	Improve range and access to services	Metro-regional
Embedding of service	New breast screening service established: • This replaces the previous provider (from March 2021), providing Breast Screening services to the Auckland DHB population	• Ongoing access to breast screening services for the Auckland DHB population • Mitigation of risks associated with no provision of screening services: increase in cancer incidence, morbidity and mortality • Equity focus: accessibility and suitability of fixed sites and options for mobile or similar are inbuilt into the model	Local for Auckland DHB (delivered by Waitematā DHB)
Change in model of care	Implementation of the Frailty Model of Care for Older People aligned with Northern Region Long Term Investment Plan. Specifically, direct admission of eligible patients with acute illness to specialist multidisciplinary care appropriate to needs. Note: this work was deferred due to COVID-19 response activities, but is now being progressed	• 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)
Implementation of new service	Implementation of the left atrial appendage closure procedure. New evidence supports 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 Ministry approval. The indications for use and implementation will	Improved patient outcomes through provision of alternative evidence-based treatment for those patients contraindicated for oral anticoagulation but who are at risk of stroke	Regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	be driven by the Northern Cardiac Network under the guidance of the regional service development workstream		
Potential change in model of service delivery	*Regional Vascular Service* The regional executive forum endorsed the development and implementation of a regional vascular surgical service with a single workforce delivering services at multiple sites across the region. A Northern Region Vascular Services Governance Group will be established to provide clinical leadership and strategic direction to the re-design and implementation of a regional model of care for vascular surgical services. This project will start in Q2 2021, with implementation in the second half of 2021	• Improved sustainability of local and regional services • Improved patient experience and outcomes	Local, regional
Shift in service	*Head and Neck Services* A regional review was completed and the region is working together to improve oversight, coordination and management. There may be a change in location of some elements of service delivery arising from the regional planning process in 2021/22	• 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 developing a new service model based on ambulatory models currently in place in New Zealand that makes the best use of available capacity and resources (including funding) to increase the number of patients assessed and treated	• Improved access • Improved clinical and financial sustainability of regional model	Regional and local
Change in model of service delivery	*Outpatient Services* Services are expected to review traditional face-to-face models 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 2021/22	• 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 integrate 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 patient needs. Note: this work was deferred due to COVID-19 response activities, but is now being progressed	• 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	*Northern Region Interventional Radiology (NRIR) Service* The NRIR Service is up and running well at Waitematā DHB and as a result, repatriation of procedures performed at Auckland DHB will commenced in 2021/22	• Local access for patients requiring more complex interventional procedures • Alternative to inpatient stay for some procedures, which will improve waiting times	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 identify where new models of service	• More efficient and cost-effective service delivery • More affordable and sustainable services	Local (Auckland DHB) Regional, national impacts

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	would deliver more efficient, affordable and sustainable tertiary services. Findings may impact the configuration and scope of some services		
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 capacity in the regional service. Further modelling to be undertaken regarding local delivery arrangements for cytotoxic chemotherapy for breast cancer patients, due to an indicated demand increase. Development of a five-year plan commenced in 2020/21 to further expand local delivery, including other tumour streams, for ongoing implementation from Q4 2021/22	• 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 New Zealand National PRRT Service was approved in principle by Ministry of Health; planned for implementation in Q1 2021/22	• 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 • Reduce requirement for patients to travel overseas to access this treatment at their own cost	National (based in Auckland DHB)
Implementation of an enhanced and regionally consistent model of care – stroke	*Stroke care/rehabilitation* • Revised model of care, agreed regionally, local delivery for all ages • Proposed integrated Stroke Unit for North Shore Hospital: business case being finalised, including impact on those aged <65 years stroke rehabilitation (i.e. move to the stroke unit rather than Rehab Plus) • Continue to full implementation of streamlined care pathways for patients as part of the integrated stroke unit at Auckland City Hospital, opened Dec 2020	• 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* The MoH National AYA Cancer Network is developing a national clinical trial pathway for AYA patients, which may lead to further service change in 2021/22	Additional regional and national service capacity developed in a planned and cost effective manner	Regional and national
Additional FTEs	Care Capacity Demand Management: 170 FTE	Required to comply with current nursing MECAs and safe staffing levels	Local (Auckland DHB; national programme)
	RMO MECA compliance: 18 FTE	Required to comply with current RMO MECA requirements	Local (Auckland DHB; national programme)
	Implementation of the Frailty Model of Care for Older People aligned with Northern Region Long Term Investment Plan: 16 FTE	Increased capacity to manage demand and acute patient flow, improved patient experience and outcomes, reduced transfers between services, early access to specialist services	Local (Auckland DHB; regional programme)
	Capacity and new business workstreams: 111 FTE	Investment in service capacity and new business streams, including Care Navigation to enable provision of services	Local (Auckland DHB)
	COVID-19 budgeted: 23 FTE	Increase in FTEs required for COVID-	Local (Auckland DHB;

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
		19-related workstreams in the Auckland Regional Public Health Services (ARPHS)	regional programme)
	Breast screening service This requires 36 FTE for baseline delivery	Improved access to service for patients	Local (Auckland DHB; service provided by Waitematā DHB)

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 (Appendix A), 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, monthly Board and Committee reporting of key Ministry of Health performance measures, monthly reporting against Annual Plan deliverables 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 (QSR) 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. As well as being part of everyone's role, dedicated quality and safety resource is spread throughout the organisation. Staff in most services have 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. A dedicated enterprise risk management team 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 QSR activities were previously delivered separately. They are now joined in a single portfolio of services, with the exception of the Performance Improvement team. In 2021/22, we will work towards ensuring these services are integrated where possible. Their focus will be on continuous improvement through the delivery of a number of key pieces of work in our identified focus areas:

- Demonstrating leadership and providing oversight to help Auckland DHB achieve its strategic goals
- Ensuring QSR are core to how we work
- Building capacity and developing the capability of the QSR Service
- Developing QSR leadership
- Improving system reliability through integrated risk management
- Moving from data to intelligence to inform learning and action.

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. Managing competing priorities in the context of uncertainty cannot be avoided in delivering the outcomes and objectives expected by our stakeholders. Understanding and managing risk is critical for our organisation to evolve and adapt to meet challenges and the changing environment in which we operate.

Embracing risk provides upsides and limits downsides. 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. Managing risk inappropriately limits the scope of what we can and need to achieve, especially in areas where there are opportunities to seek change, the problems are complex and the solutions are far from clear-cut, such as in addressing equity.

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 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 completed the second round of Investor Confidence Rating (ICR) in 2019 and maintained our B rating, achieved in 2016. Maintaining the same rating is an achievement for the DHB, as 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 elements were more strict. 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 develop improvement initiatives. We implemented several 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 developed and are implementing business cases that address the condition and functionality of our assets, and to enable us to continue to provide 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 continue to improve our project, programme and portfolio management maturity. The focus for the Enterprise Portfolio Management Office (EPMO) is to support the organisation to gain improved visibility and transparency of project work, the value gained from change initiatives and the impact on resources. We are collaborating regionally to improve our business case standards to lift the quality of our cases to support good investment decisions. We are also working regionally to develop a benefits management framework to support improved capability in benefits identification, analysis and planning. The framework is an enabler for improving the line of sight from regional strategy through to delivery of change, and to set out a common language and framework of benefits and indicators so that we can better demonstrate and share project outcomes and learning. We are also using these regional initiatives as an opportunity to help embed equity, sustainability and wellbeing into all facets of project prioritisation, development and delivery.

Northern Region Planning

2021/22 is the third year of implementation of our Northern Region Long Term Investment Plan (LTIP), published in 2018 for the period 2018-2037. Our investment plan sets out agreed changes in our models of care, the planning and commissioning of services in our region, and the capital, workforce, and information technology to deliver our future vision for the health system. Our strategy addresses the three key strategic challenges faced by the Northern Region:

1. Health status is variable; there are significant inequities for some population groups and geographic areas, as well as a large burden of ill health, which need a rebalancing of investment into prevention and early intervention.
2. Health services are not sufficiently centred around the patient and whānau; in certain areas, the quality, safety and outcomes of care are not optimal, which require proactive networked care, centralising where beneficial for quality, and localising where beneficial for access, in co-designed services that enable choice and control for whānau.
3. The needs of our rapidly growing, ageing and changing population are not clinically or financially sustainable with our current capacity and models of care; new approaches are needed to moderate the demand for hospital care and enhance productivity and efficiency of services.

Our DHB annual plan, together with the agreed regional work programme, aims to deliver on the commitments set out in our DHB and Northern Region strategies, including our fundamental Te Tiriti commitments.

In line with national guidance with no mandatory Ministry requirements for a Regional Services Plan in 2021/22, our strategy remains as an extension of our 2020/21 Regional Service Plan. Our regional work programme for 2021/22 builds on the key themes that we delivered or initiated in 2020/21, including:

- Delivering and implementing transformational changes to our models of care for vulnerable services to achieve resilience, quality and equity

- Transforming diagnostics through regional pathology and imaging programmes
- Continuing an equity-led recovery from COVID-19 in our Planned Care wait times and improving our collaboration in managing capacity
- Continuing to strengthen our regional emergency preparedness and response
- Further progressing our extensive workforce modernisation programme
- Rapid developments in IT systems to support COVID-19 and to leverage broader change
- Continue to improve care through regional clinical networks to support cancer, cardiac care, stroke, trauma, hepatitis C elimination, mental health and addiction, child health and child development services.

In the coming year, we aim to strengthen this by:

- Expanding Māori and Pacific health gain programmes, contributing to equity
- Developing the next level of detail in our longer-term clinical service, capital and technology plans.

Our Planning commitments in 2021/22 include:

- Developing a longer-term capital road map (2025-2037) in partnership with the Ministry of Health
- Combining our LTIP with our sector-specific deep dives in primary and community services, public and population health, and with spatial clinical service planning to form a refreshed LTIP
- Horizon two for our Information Systems Strategic Plan, moving from foundations to the underpinning technology to deliver transformational clinical service change
- Incorporating changes to ways of working within the region and in DHBs in line with the year one plans of the government's response to the Health and Disability Review.

All of our 2021/22 programmes of regional collaborative work align with national, and our regional, strategic directions. This regional work will continue to be delivered through well-established mechanisms functioning under regional oversight and regional governance groups with the continuing leadership and engagement of the Chairs, Chief Executives and Chief Medical Officers of all four DHBs.

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, when they 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
- provide digital support for our COVID-19 response
- improve the maturity of our regional cyber-security capability
- invest in electronic support of clinically-led service initiatives.

Refer to Section 2, Data and digital enablement for further information.

Strengthen workforce culture

People, culture and values are one of three pillars that underpin our strategy for Auckland DHB. Pūmanawa Tāngata (our three-year people strategy) puts people at the centre, provides direction and reflects what is important to us so that we can deliver the best health outcomes for our population.

The plan supports our people to respond to the changing landscape in health as we continue to work in a resource-constrained system and respond to COVID-19, Wai 275 and the Health and Disability Review.

Six key areas were identified to help us achieve our strategy and make sure Auckland DHB is a great place to work and a great place for care. Together, they contribute to strengthening a positive workforce culture that supports our people to thrive and be at our best for patients, whānau and each other:

- Strengthen our organisational culture and values

- Build capability to achieve equity
- Grow and develop ngā kaimahi Māori
- Create a healthy workplace through Kia Ora to Wahi Mahi
- Attract and grow a workforce fit for the future
- Make it easier to work here.

Strengthen our organisational culture and values

We will use our strong values framework to support health equity and reflect our commitment to Te Tiriti o Waitangi. Cultural safety for our workforce is a key component to achieving this.

By continuing to improve communications and connections, we will enhance the mana of those we interact with. We want to make feedback safe and easy to give so we can continue to learn and grow. We will continue to support a safe and inclusive workplace for our Rainbow and Accessibility workforce.

Build capability to achieve equity

We will develop a widespread understanding of our responsibilities under Te Tiriti o Waitangi and ways in which we enact them every day to improve health equity.

Building a common understanding of equity, embedding cultural safety and competency across the organisation is integral to providing equitable care. This will include developing the learning outcomes framework, Ngā Poū Akoranga o Pae Ora to, build understanding of Te Tiriti o Waitangi, Tikanga best practice, and mātauranga Māori.

Grow and develop ngā kaimahi Māori

Growing and developing our Māori workforce is integral to achieving equitable services and Māori health gain. We will work with our Māori workforce to better understand their experience with us so we can inspire more kaimahi Māori to work, learn and grow at Auckland DHB. We will support genuine partnership with kaimahi Māori in decision-making, and providing opportunities to contribute to work focused on Māori health gain.

Health and safety and healthy workplaces

We recognise the importance of providing a safe environment for our people, patients, visitors and contractors. 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 and injury rates, and fully support workers who experience an injury in our workplace.

Kia Ora tō Wāhi Mahi is the Healthy Workplace plan for Auckland DHB. Our people's wellbeing and experience is important to us and we know that our people's experience affects patient experience and health outcomes. Our approach is grounded in Te Whare Tapa Whā, it recognises mātauranga Māori and addresses wellbeing in a holistic sense.

We will partner with our people to ensure they feel safe, supported and cared for. A key part of this will be our leaders so they have the health, safety and wellbeing capability to champion and role model a healthy culture. This means:

- Providing assurance that we are meeting our moral, ethical, socio-legal, environmental and economic obligations
- Having a shared understanding of our health and safety obligations and risks
- Increasing the capability of leaders and employees to identify, take action on and monitor health and safety and mental health issues in the workplace
- Having resources in place to support capability of people to provide structured, tailored physical, environmental and psychological injury management and return to work programmes
- Reviewing the range of psychological supports for our people to promote psychological safety, mitigate the impact of events at work and support each other when life is impacting work
- Improving and developing our health and safety governance and strategy
- Reviewing and updating our health and safety management system to reflect current best practices and standards.

We will integrate this into all aspects of our operations by creating a culture that actively encourages good health and safety practices and by applying effective policies, standards, systems and processes, and solid, quantifiable performance objectives to measure our success.

Refer to Section 2, Health workforce for further information.

Attract and grow a workforce fit for the future

Our people showed stunning agility in response to COVID-19 we will use lessons learned to work in a more agile way, anticipating and responding to change. We will equip leaders to manage learning teams who can adapt to the many challenges facing healthcare. We will make this a place where everyone has the opportunity to learn and grow.

COVID-19 will have lasting impacts on both the national and international labour markets. There are many people who may now see the sector as one in which they would like to be part of; we may need to think creatively about how we attract and develop those people.

Making it easier to work here

We will focus on the systems that support those processes. We will do that in several ways. We make it easier to work here by changing systems, processes, and approaches. This will enable our managers and people to focus on important strategic outcomes so we can be at our best for patients, whānau and each other.

Collaboration

We continue to collaborate closely with other DHBs, particularly our colleagues in the Northern Region. We commit 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. As a significant training facility, we work alongside our tertiary education partners to optimise student experience when we host student placements across a range of clinical professions.

We will continue to work with community and primary care providers to support community-based attachments based on need. We will refine the PGY1 curriculum in respect of non-technical expertise and develop and deliver a new curriculum for PGY2.

We will partner with schools in our community to provide workplace experience opportunities (e.g. the Rangatahi Programme).

SECTION 5: Performance Measures

2021/22 Performance measures

The following table presents the full suite of Ministry of Health 2021/22 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 (aged 0-4 years) enrolled in COHS	Year 1	≥95%
	Year 2	≥95%
Children (aged 0-12 years) overdue for their scheduled examinations with COHS	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	The DHB has reached the 'total population' target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets	55% by 6 weeks 85% by 3 months
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 health initiatives		
Focus area 1: Youth SLAT	Provide reports as required	
Focus area 2: School Based Health Services	Provide reports as required	
Focus area 3: Youth Primary Mental Health services	Refer to MH04	
Improving mental wellbeing (MH)		
MH01 Improving the health status of people with severe mental illness through improved access (CY2019 baseline)	Age 0-19 years Māori Other	≥3.38% ≥6.00% ≥3.05%
	Age 20-64 years Māori Other	≥3.92% ≥11.46% ≥3.29%
	Age 65+ years Māori Other	≥3.11% ≥3.64% ≥3.03%
MH02 Improving mental health services using wellness and transition (discharge) planning	% of clients discharged will have a quality transition or wellness plan	95%

Performance measure		Expectation
	% of audited files meet accepted good practice	95%
MH03 Shorter waits for non-urgent mental health and addiction services (0-24 year olds)	Provide reports as specified	
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	↓ by ≥10% (baseline is Q3 2020/21)
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	Provide reports as specified	
Improving wellbeing through prevention (PV)		
PV01 Improving breast screening coverage and rescreening	% coverage for women aged 45-69 years for Māori, Pacific and total population	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%
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	Refer to our 2021/22 SLM Improvement Plan
	Age 45-64 years	≤3,562 per 100,000
SS07 Planned Care measures		
1. Planned care interventions	Number of interventions	TBC
2. Elective service patient flow indicators	ESPI 1: 100% (all services) report Yes (that >90% of referrals within the 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%
	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)	The proportion of patients who were acutely re-admitted post discharge improves from base levels	<11.6%

Performance measure		Expectation
7. Did not attend rates (DNA) for first specialist assessment (FSA) by ethnicity	Developmental measure – no target	
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%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
	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	≥85% and <95%
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, milestones and measures 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%
	≥95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within 30 days, and ≥99% within 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%
	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 a 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% (5classes) * 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%
	≥99% of patients who have pacemaker or implantable	≥99%

Performance measure		Expectation
	cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure	
Focus area 5: Stroke Services	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway within 24 hours of their presentation to hospital	80%
	12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	12%
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	60% 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 and the current results from Stage 3 EDAT show a level of match in ethnicity data of >90%	100%
PH03 Access to care (Māori PHO enrolments)	The DHB has an enrolled Māori population of 95% or above	95%
PH04 Better help for smokers to quit (primary care)	% 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

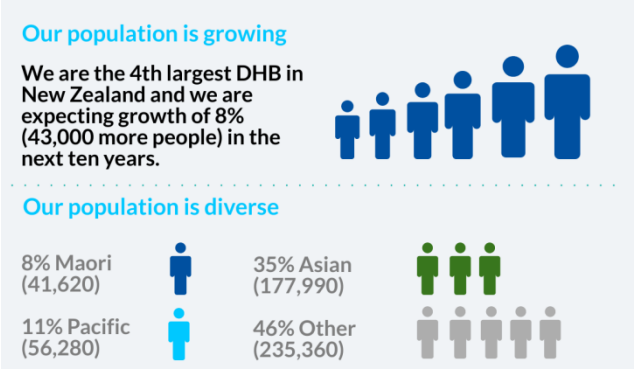
APPENDIX A: STATEMENT OF INTENT – 2019/20 to 2022/23

About Auckland DHB

Who we are

Auckland DHB is the Government's funder and provider of health services to the estimated 511,000 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 DHB residents is younger than New Zealand as a whole, with 35% in the 25-44 year-old group, compared with 28% in this age group nationally. Auckland DHB has 12% of its population in the 65+ year old group, compared with 16% nationally.

Our population is diverse and rapidly growing. 8% of Auckland DHB residents are Māori, 11% are Pacific, and 35% are Asian. Over 45% of our population were born overseas. Our Asian population is proportionally our fastest growing population, and is projected to increase to 40% of the total in the next ten years.

Auckland DHB'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. 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 motu, with 9.6% who are current smokers (Census 2018 Usually Resident Population).

Cardiovascular disease (CVD) is the most common cause of death for residents of Auckland DHB (30%). Cancer is the second highest cause of death (27%), and there were close to 2,100 new cancer registrations in Auckland in 2019 (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 years are amenable through healthcare interventions (45% or 400 deaths in 2017).

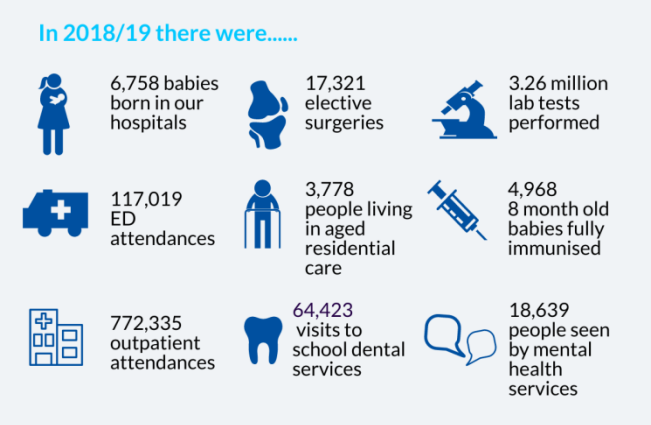
We have a similar deprivation profile to New Zealand as a whole. Almost one in five (18%) of our total population and 29% of Māori and 45% of Pacific people live in the poorest areas (quintile 5, NZDep2018), concentrated in Rosebank/Avondale in the west, Mt Roskill and the CBD, and the eastern and southern 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

Our 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. Auckland DHB employs around 12,000 people.

We have an expenditure budget of $2.9 billion in 2021/22.

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 all four of the 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 554,000 over the next 10 years, and the 65+ year-old population will increase by nearly 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 CVD 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 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 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
   - tight cost control to limit 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 and 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:
   - focusing 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
   - Addressing 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 committed to the Northern Region Long-Term Health Plan (NRLTHP) 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 were developed by the Executive Leadership Team and account for most of the new activity scheduled for the year.

Strategic outcome	Strategic risk	Strategic programme
Healthy communities Achieving the best, most equitable health outcomes for the populations we serve	• Meet our Tiriti o Waitangi obligations and achieve equitable outcomes across different population groups • Provide 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	• Retain high quality care and good health outcomes as demands increase • Provide the best specialist services for the rest of the motu within budget • Work well and efficiently with our neighbouring DHBs • Be prepared to respond to any sudden health or infection incidents • Develop 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	• Maintain a great workforce culture that staff and our public are proud of • Provide services in the event of any IT systems disruption or natural disasters • Keep 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 the Government's 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 responding to COVID-19, health promotion and protection, and undertaking regulatory functions.

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).

Sub-regional

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 co-ordination of care to improve access, equity and outcomes of health care, and reduce duplication.

Delivering on our strategy

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 continue to 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. Outpatient services are becoming easier 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. This programme will 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 ensures critical facilities infrastructure is operational, and will 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 PHO and NGO partners to upscale and evaluate interventions that support people with moderate mental health needs.

Building for the future. 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

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 the needs of our Māori and Pacific.

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 NRLTHP. 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 MOCs 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. Refer to Section 1, Our strategy for health, wellbeing and equity for details of our updated strategy for 2020-23.

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 we fund or provide contribute to the health of our population and achieve our longer-term outcomes and the expectations of the 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; less than half of all Māori and around half of Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the number of babies living in smokefree homes.

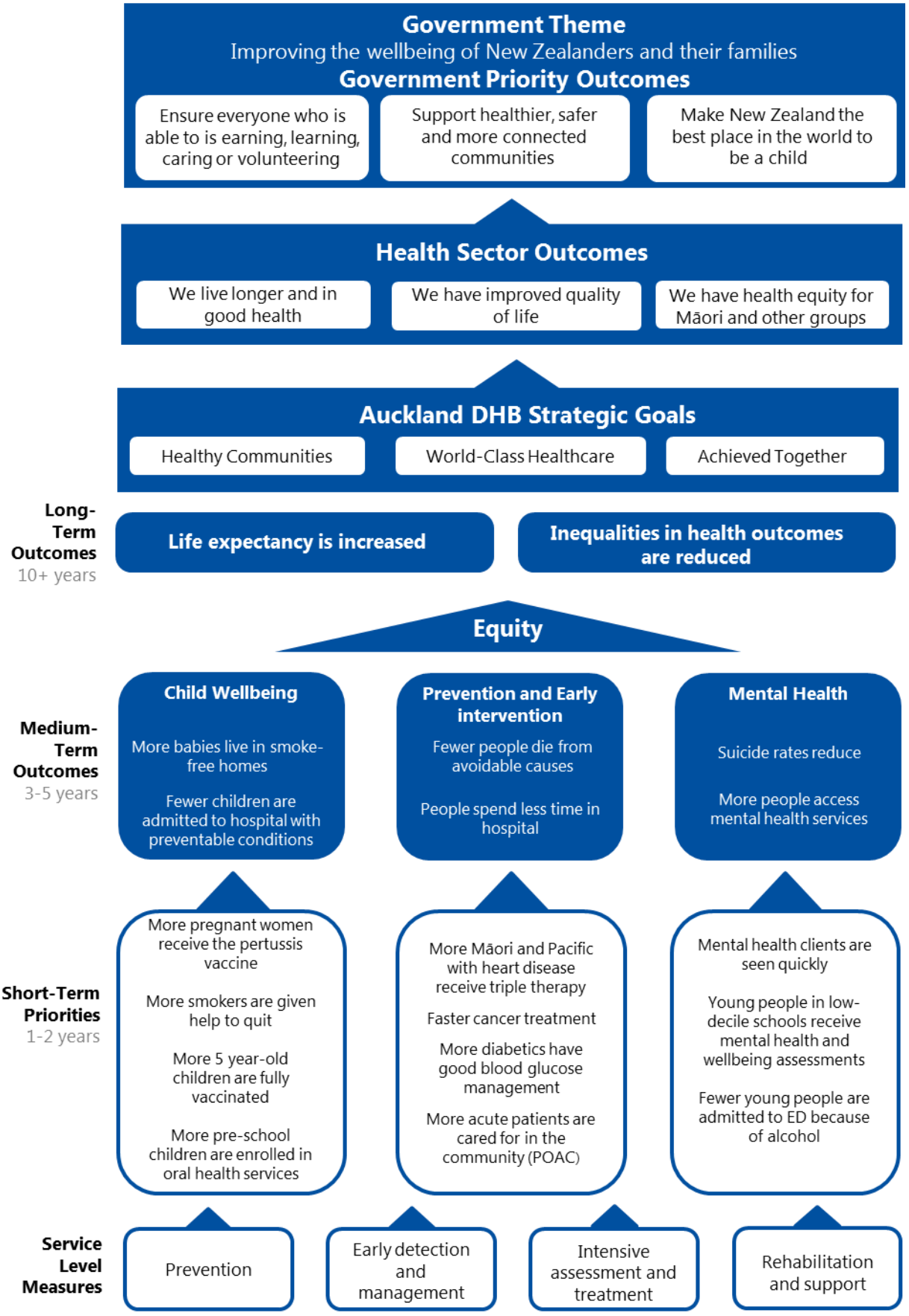
Pacific children, in particular, have very high hospital admission rates for conditions that can be potentially prevented or managed by primary and community care. We will improve vaccination rates and access to oral health services to help keep these children out of hospital.

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% experiencing 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, with 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).

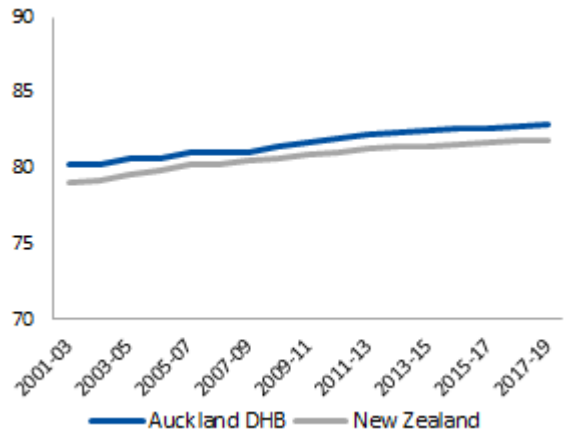
Increasing life expectancy

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 motu, at 82.9 years (2017-2019), which is 1.1 years higher than New Zealand as a whole. In Auckland DHB, life expectancy 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.

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

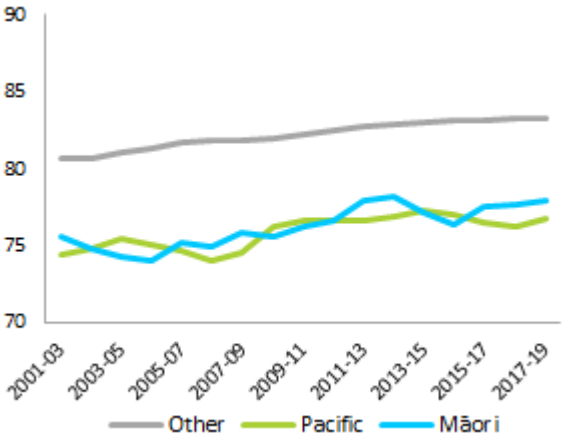
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 6.2 years for Māori and 7.3 years for Pacific (2017-2019).

Life expectancy has increased in both 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. 'Other' ethnicity includes non-Māori/non-Pacific ethnicities.

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.

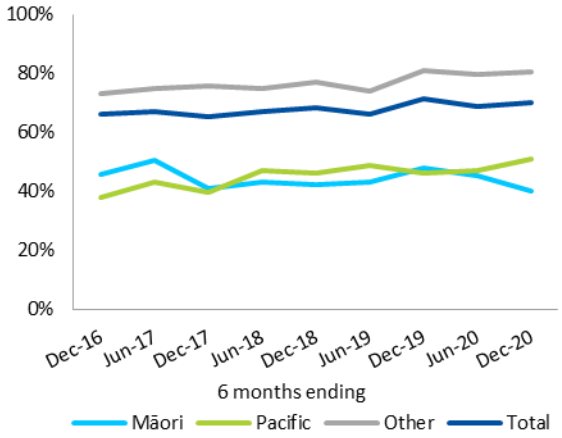
Medium-Term Outcomes

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 2020, less than half of all Māori and around half of Pacific babies were living in a smokefree household in contrast to more than three quarters of other ethnicities. The proportion of all babies who live in smokefree households has improved for Pacific, but declined for Māori.

Proportion of babies living in smokefree households at 6 weeks postnatal



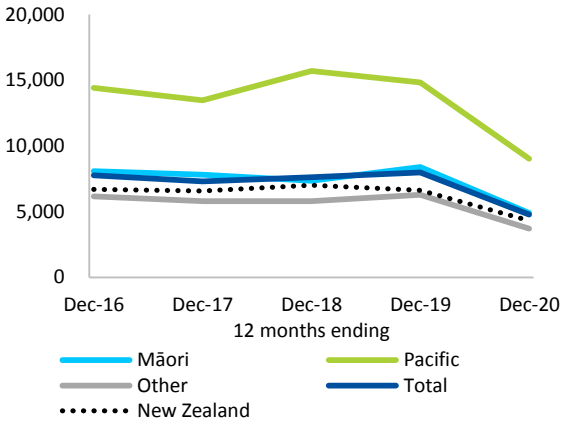
Fewer children are admitted to hospital with preventable conditions

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.

A significant reduction in ASH admissions was observed in the 12-month period ending December 2020. This is because many people avoided seeking treatment at healthcare facilities, including hospitals, during the COVID-19 Alert Level 4 lockdown in March-April 2020. The incidence of some ASH conditions also decreased through the efforts to reduce the spread of COVID-19; seasonal influenza and other respiratory infection rates dropped due to social distancing and good hygiene practices, as well as improved vaccination rates. Performance will need to be monitored over time to determine if this improvement is sustained.

ASH rates remain higher in Māori (4,897 per 100,000) than other ethnicities (3,711 per 100,000), and over twice as high in the Pacific population (9,019 per 100,000).

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



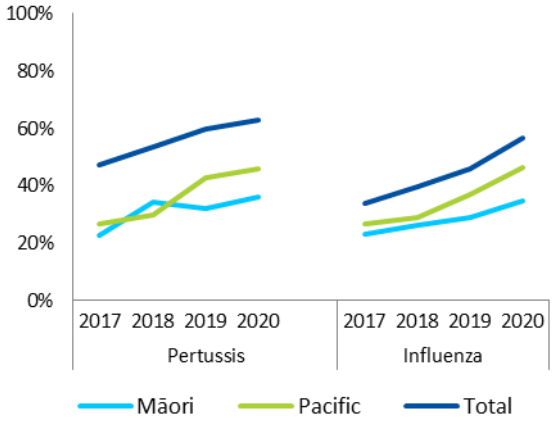
Short-Term Priorities

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.

Vaccination rates are increasing. For babies born in 2020, 63% of mothers received a pertussis vaccination during pregnancy and 57% received an influenza vaccination; however, the rates are much lower for Māori and Pacific.

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



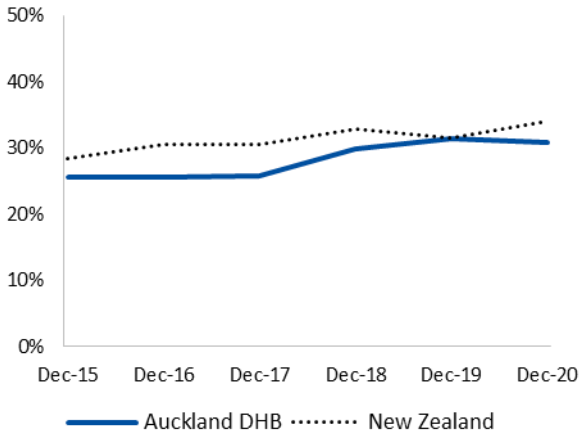
More smokers receive help to quit

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, is provided.

As at December 2020, 31% of smokers were provided with smoking cessation support in the past 15 months.

Proportion of smokers receiving cessation support in primary care



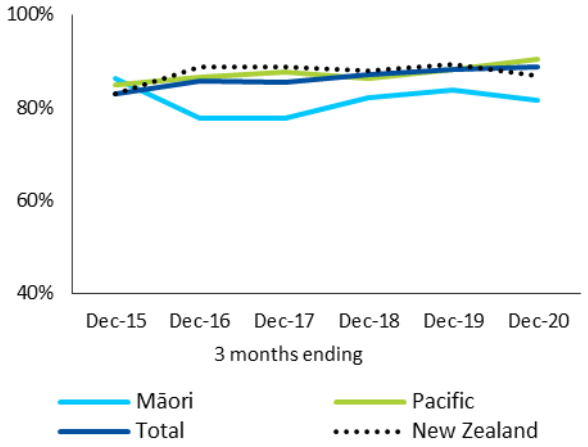
More five year-old children are fully vaccinated

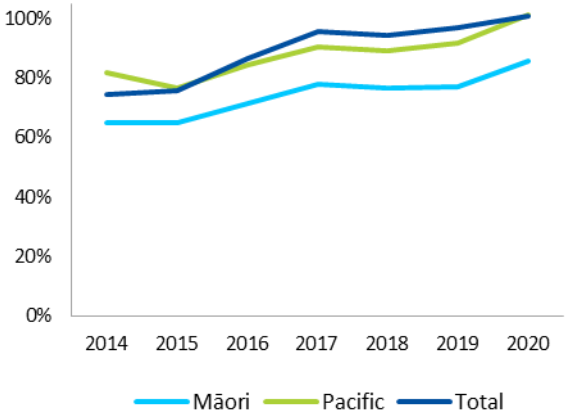
Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and even death. Immunisation protects not only the child, but others that are unable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

In the quarter ending December 2020, 89% of all five-year old children were fully vaccinated, higher than the national rate; however, the rate is significantly lower for Māori children (82%).

Proportion of children fully vaccinated by five years of age

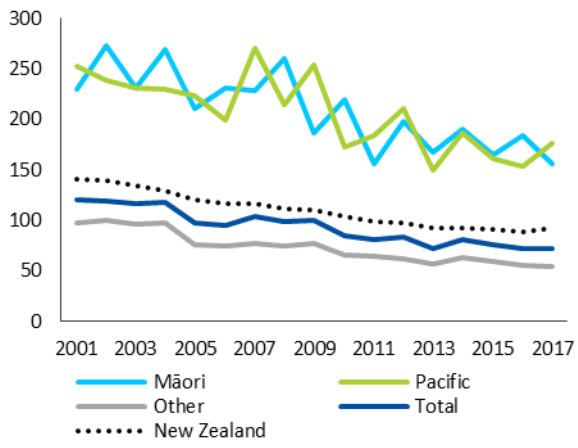


More pre-school children are enrolled in oral health services	
Dental conditions are a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions. Dental care for preschool children is free; however, not all children are enrolled in oral health services, with Māori children in particular missing out on dental care. Note: the denominator for this measure is the estimated population, as published by Statistics NZ, as it is not possible to have an exact count of all the children in our district at any point in time. As at December 2020, the estimated population (25,130) was lower than the actual number of children enrolled with oral health services (25,305), therefore the calculated result is 100.7%. While we know not all children are enrolled with oral health services, the number of enrolled children is increasing and we are confident we are close to achieving our aim of all children 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 of illness can significantly affect 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

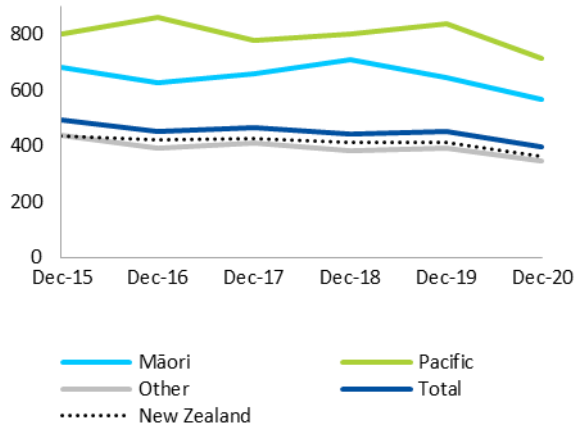
Fewer people die from avoidable causes	
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care where such health interventions exist. In 2017, we estimate that 400 deaths (45% of all deaths in those aged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

A reduction in acute bed days was observed in the 12-month period ending December 2020, as some people avoided seeking treatment at healthcare facilities, including hospitals, during the Alert Level 4 lockdown in March-April 2020.

Acute hospital bed days per 1,000 population



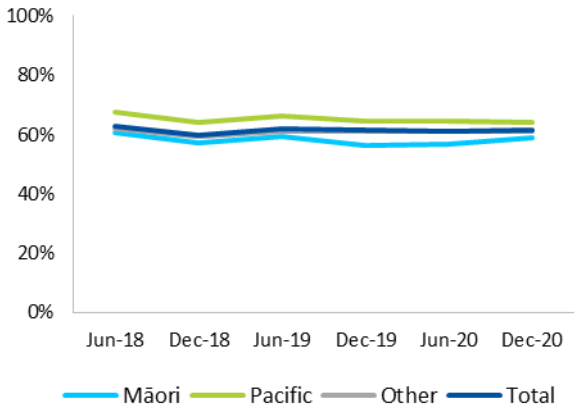
Short-Term Priorities

More Māori and Pacific with heart disease receive triple therapy

New Zealand guidelines recommend that, where appropriate, people who previously had 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 to treat hypertension and a statin to reduce cholesterol), to reduce the risk of another cardiovascular disease (CVD) event.

As at December 2020, 59% of Māori and 64% Pacific who had a previous CVD event were prescribed triple therapy medication.

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



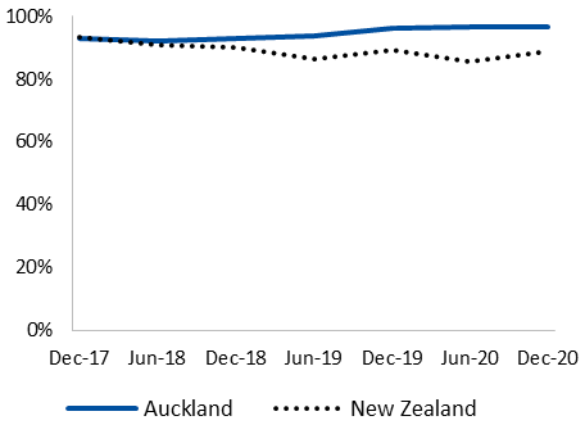
Faster cancer treatment

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 for all patients diagnosed with cancer to receive their first treatment or other management within 62 days of referral.

In the six months to December 2020, 97% of cancer patients received their first treatment within the target time.

Proportion of cancer patients receiving treatment within 62 days of referral



More people with diabetes have good blood glucose management

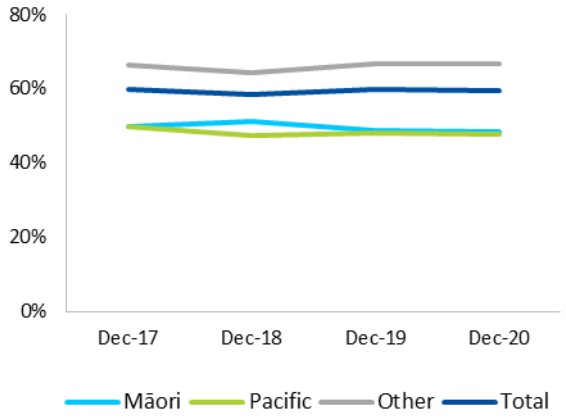
The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to help manage their condition and make lifestyle changes.

HbA1c is a measure of a patient's average blood glucose level over the past few months and can be used as an indicator of how well their diabetes is being controlled.

Well managed diabetes decreases the likelihood of onset and progression of microvascular complications, such as retinopathy, nephropathy and neuropathy.

As at December 2020, 60% of all people with diabetes had an HbA1c of ≤64mmol/mol, indicating their diabetes is well managed.

Proportion of diabetics with good blood glucose management



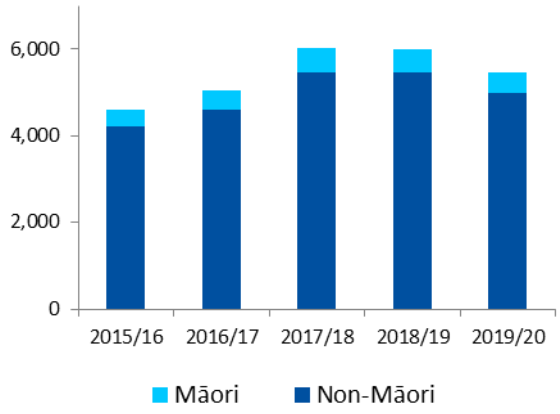
More acute patients are cared for in the community (POAC)

Primary Options for Acute Care (POAC) provides access to investigations, care or treatment in the community so that patients can be safely managed by primary care at home, thus avoiding acute hospital admissions or shortening hospital stays.

We aim to have more people treated through the POAC pathway, thus preventing unnecessary and costly acute hospital admissions.

In 2019/20, 5,462 patients were referred to POAC services. The decrease in referrals observed in 2019/20 is largely due to the impact of the Alert Level 4 restrictions in place during March-April 2020.

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 show signs of mental distress and intentional self-harm. In addition, New Zealand has persistently high suicide rates. The responsibility for 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 who need it. Our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

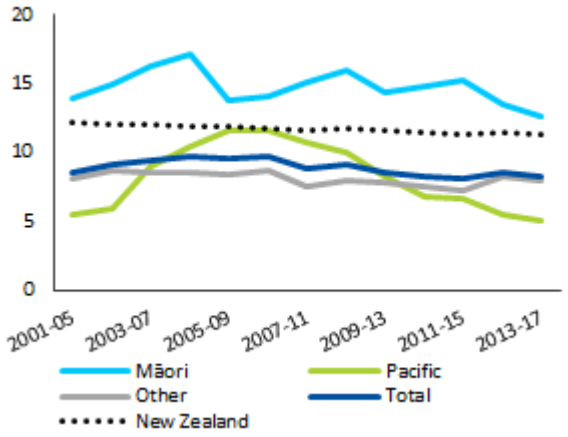
Medium-Term Outcomes

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 support wellbeing and address multiple social determinants.

Rate of suicide per 100,000 population

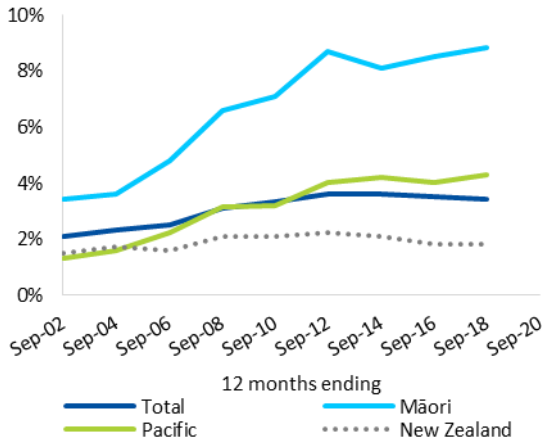


More people access mental health services

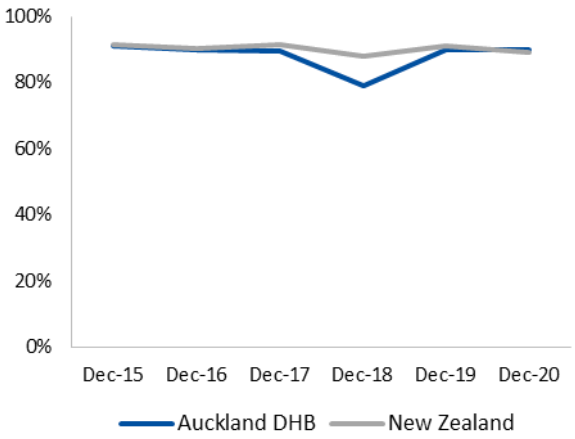
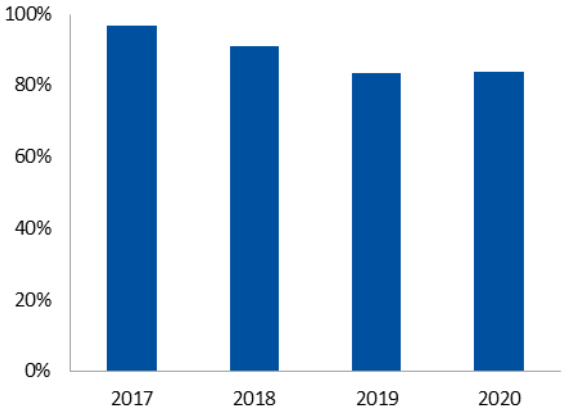
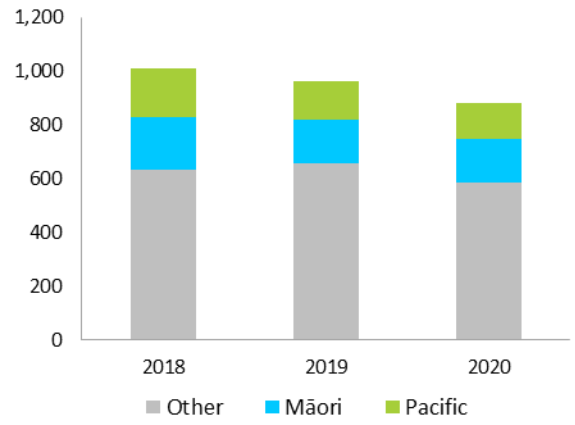
Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people show signs of mental distress and intentional self-harm. While not all individuals with mental health and addiction challenges needs or will seek access to a specific service intervention, over time, more people should be able to access support.

In the 12 months to September 2020, 3.8% of the total Auckland DHB population was seen by specialist mental health services. The prevalence of mental distress is much higher in Māori than other ethnicities, and nearly one in ten Māori (9.2%) accessed mental health services in the same period.

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. In the 2020 calendar year, 89.8% of people referred non-urgently to mental health services was seen within 8 weeks.	**Proportion of referrals to non-urgent 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, and can be a potentially dangerous time of experimentation. HEEADSSS is a validated assessment tool 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, their risk and protective factors, and the environment around them. In the 2020 school year, 90% of eligible students received a HEEADSSS assessment, a similar rate to the previous year.	**Proportion of eligible Year 9 students receiving HEEADSSS assessment** 
Alcohol is the most commonly used recreational drug in New Zealand, and young people are at a higher risk of harm from alcohol use than older adults. Identifying and monitoring alcohol-related emergency department (ED) presentations enables DHBs to better understand the impact of excessive alcohol consumption on young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals, including to primary care and community care. There were fewer alcohol-related ED admissions recorded in 2020 than previous years; however, some of this reduction is likely due to lower numbers of overall ED attendances during the COVID-19 outbreak in early 2020.	**Alcohol related ED admissions for youth aged 10-24 years** 

APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS AUCKLAND DHB 2021/22

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for 2021/22.

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. Performance measures are concerned with the volume (V), quality (Q), timeliness (T) and population coverage (C) of service delivery. Actual performance against these measures will be reported in our audited Annual Report year end.

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 2022 (Appendix C) and the Financial Performance Summary table (Section 2) form part our 2021/22 SPE.

Four Output Classes (Prevention, Early Detection and Management, Intensive Assessment, and Treatment and Rehabilitation and Support) are to be used by all DHBs to reflect the nature of services provided. These classes include outputs we propose to supply in the financial year and are directly funded (in whole or in part) by the Crown in accordance with: an appropriation for the purpose; by grants distributed under any Act, or by levies, fees, or charges prescribed by or under any Act.

Statistics New Zealand and the Ministry of Health released updated population estimates and projections in late 2020 based on the 2018 Census. Many of our measures and targets rely on this data, so there may be changes in both performance and target data when comparing this Plan to previous plans and reports.

The COVID-19 outbreak in early 2020 saw a significant reduction in clinical activity because of restrictions under the lockdown period, the re-purposing of staff and facilities for COVID-19 functions, and members of the public choosing not to access health services. Data collection was also affected. This has affected the performance of many 2019/20 results, therefore the 2019/20 baseline result may not be an accurate indicator of expected 2021/22 performance. Measures significantly affected by COVID-19 have been identified in the footnotes.

In August 2021, the Government announced the introduction of the Health System Indicators framework to replace the previous national Health Targets as the new monitoring and reporting framework for the health and disability system. This is an initial set of 12 high level, national indicators focused on the Government's priority areas, listed in the table below. The first update will be published in December 2021 and will report by DHBs for the July-September quarter of 2021/22. The Ministry and the Health, Safety and Quality Commission will work with the Transition Unit and sector stakeholders during 2021/22 to further develop the framework and ensure it complements overarching monitoring and accountability arrangements for the health and disability system.

Government priority	High-level indicator	Description
Improving child wellbeing	Immunisation rates for children at 24 months	Percentage of children who have all their age-appropriate schedule vaccinations by the time they are two years old
	Ambulatory sensitive hospitalisations for children (age range 0-4)	Rate of hospital admissions for children under five for an illness that might have been prevented or better managed in the community
Improving mental wellbeing	Under 25s able to access specialist mental health services within three weeks of referral	Percentage of child and youth accessing mental health services within three weeks of referral
	Access to primary mental health and addiction services	In development
Improving wellbeing through prevention	Ambulatory sensitive hospitalisations for adults (age range 45-64)	Rate of hospital admissions for people aged 45-64 for an illness that might have been prevented or better managed in the community

Government priority	High-level indicator	Description
	Participation in the bowel screening programme	In development
Strong and equitable public health system	Acute hospital bed day rate	Number of days spent in hospital for unplanned care including emergencies
	Access to planned care	People who had surgery or care that was planned in advance, as a percentage of the agreed number of events in the delivery plan
Better primary health care	People report they can get primary care when they need it	Percentage of people who say they can get primary care from a GP or nurse when they need it
	People report being involved in the decisions about their care and treatment	Percentage of people who say they felt involved in their own care and treatment with their GP or nurse
Financially sustainable health system	Annual surplus/deficit at financial year end	Net surplus/deficit as a percentage of total revenue
	Variance between planned budget and year end actuals	Budget versus actuals variance as a percentage of budget

Performance measurement framework

Our focus for 2021/22 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. Measures with a target of Ω are demand driven, where it is not appropriate to set a target.

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

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 2019/20	Target 2021/22
Health promotion			
% of PHO-enrolled patients who smoke are offered brief advice to stop smoking in the last 15 months	C	87%	90%
% of PHO-enrolled patients who smoke and are referred to smoking cessation providers	Q	9%	6%
% of PHO-enrolled patients who smoke and are prescribed smoking cessation medications	Q	8%	12%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	154	110
Number of clients engaged with Green Prescriptions	V	3,623[1]	4,030
% of clients engaged with Green Prescriptions	C		
- *Māori*		*13%*	*11%*
- *Pacific*		*22%*	*17%*
- *South Asian*		*15%*	*17%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy	C	60%	50%
- *Māori*		*34%*	
- *Pacific*		*42%*	
- *Asian*		*71%*	
% of pregnant women receiving influenza vaccination in pregnancy	C	51%	50%
- *Māori*		*34%*	
- *Pacific*		*42%*	
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness	C	20%	30%
- *Māori*		*10%*	
- *Pacific*		*14%*	
% of eight months olds will have their primary course of immunisation on time	C	93%	95%
- *Māori*		*85%*	
- *Pacific*		*91%*	
% of five year olds will have their primary course of immunisation on time	C	89%	95%
- *Māori*		*84%*	
- *Pacific*		*89%*	
- *Asian*		*91%*	
Rate of HPV immunisation coverage	C	86%	75%
Population-based screening			
% of women aged 45-69 years having a breast cancer screen in the last 2 years	C	67%[1]	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	69%[1]	80%
HEEADSSS assessment coverage in DHB-funded school health services	C	84%[2]	95%
% of 4 year olds receiving a B4 School Check	C	65%[1]	90%
% of newborn babies offered and received completed hearing screening within 1 month	V	95%	90%
Bowel cancer screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit[3]	Q	New indicator	60%
- *Māori*			
- *Pacific*			
- *Asian*			
- *Other*			

[1] The performance of this measure was significantly affected by COVID-19 in 2019/20.
[2] 2019 school year.
[3] Proportion of people invited to take part in the programme who were screened in the two years prior to the reporting period.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
% 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	T	New indicator	95%
Auckland Regional Public Health Service[4]			
Number of alcohol licence applications and renewals (on, off club and special) that were processed	V	3,625	Ω
Number of tobacco/vaping retailer compliance checks conducted	V	184	300
% of smear-positive pulmonary tuberculosis cases contacted by a public health nurse within 3 days of clinical notification	T	95%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	96%	90%
% of COVID-19 confirmed cases that started isolation/quarantine within 48 hours after notification (time case notification to isolation/quarantine of contact P002)	T	New indicator	≥80%

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 2019/20	Target 2021/22
Primary health care			
Rate of primary care enrolment in Māori	C	82%	95%
% of newborn babies enrolled with a general practice or primary health organisation (PHO) at 3 months of age - *Māori* - *Pacific*	C	91% *80%* *85%*	85%
Primary Options for Acute Care (POAC) utilisation rate	Q	0.91%	3%
% 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	11% *16%* *12%*	<8%
% 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% *50%* *49%*	60%
% of the highest priority (priority 1) patients who are not known to retinal screening, in Auckland DHB clinics - *Māori* - *Pacific* - *Asian* - *Other*	C	810[5] 99[5] 500[5] 132[5] 79[5]	≤406 ≤50 ≤250 ≤66 ≤40
% of Māori and Pacific patients with prior CVD who are prescribed triple therapy - *Māori* - *Pacific*	Q	 *56%* *65%*	70%
Pharmacy			
Number of prescription items subsidised	V	7,387,260	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	26,739	Ω
Number of community laboratory tests	V	3,213,918	Ω

[4] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[5] Baseline is data as at March 2021.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Oral health[6]			
% of preschool children enrolled in DHB-funded oral health services - *Māori* - *Pacific* - *Asian*	C	97% *77%* *92%* *93%*	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - *Māori* - *Pacific* - *Asian*	Q	0.63 *0.81* *0.93* *0.58*	<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	87%	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 an improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
Acute services			
Number of ED attendances	V	109,215[1]	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	87%	95%
% 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	96%	90%
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	C	14.3%	12%
% of ACS inpatients receiving coronary angiography within 3 days	T	84%	70%
Maternity			
Number of births in Auckland DHB hospitals	V	6,634	Ω
Elective (inpatient/outpatient)			
Number of planned care interventions - *Inpatient surgical discharges* - *Minor procedures* - *Non-surgical interventions*	V	21,578[1] 13,466 8,111 1	TBC
% of people receiving urgent diagnostic colonoscopy in 14 days	T	96%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	39%[1]	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	15.5%[1]	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	85%[1]	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	52%[1]	90%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	n/a[7]	80%
% of hip and knee arthroplasty operations where antibiotic is given in one hour before incision	Q	n/a[7]	100%
% of hip and knee procedures given right antibiotic in right dose	Q	n/a[7]	95%

[6] To align with the school year, all baseline results are for the calendar year prior to the end of each financial year, i.e. CY2019.
[7] In response to the COVID-19 pandemic, the Health Quality & Safety Commission temporarily suspended the requirement for DHBs to report on manually collected quality and safety marker measures from 23 March to 30 June 2020, therefore 2019/20 results are unavailable.

Outputs measured by	Notes	Baseline 2019/20	Target 2021/22
% of patients audited for pressure injury risk who received a score	Q	92%	90%
% of patients with a hospital-acquired pressure injury	Q	1.8%[8]	<3.0%
% of 'yes, always' responses to the HQSC Adult Hospital survey question: *'Was your name pronounced properly by those providing your care?'*	Q	89.1%[9]	≥89.1%
% of 'very good' and 'excellent' responses to the Auckland DHB inpatient survey question: *'How would you rate the coordination of your care between the hospital, home and other health services after you were discharged from hospital?'*	Q	66.7%	70%
Mental Health			
% of population who access Mental Health services	C		
- Age 0–19 years		3.38%	≥3.38%
- *Māori*		*5.93%*	≥6.00%
- Age 20–64 years		3.95%	≥3.92%
- *Māori*		*11.76%*	≥11.46%
- Age 65+ years		3.17%	≥3.11%
- *Māori*		*4.33%*	≥3.64%

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 2019/20	Target 2020/21
Home-based support			
% 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	n/a[10]	95%
Palliative care			
Number of community contacts (nurses)	V	8,143	Ω
% of patients acutely referred who waited >48 hours for a hospice bed	T	0%	<5%
Residential care			
ARC bed days	V	997,066	Ω

[8] CY2019 result.
[9] Nov 2020 to Feb 2021 result.
[10] Due to COVID-19, service provision in Q4 2019/20 was reduced to minimise transmission risk, and providers were switched to fixed funding rather than fee for service, which means accurate data for this measure is not available for 2019/20.

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.

We manage cost growth at Auckland DHB through a financial sustainability programme that delivered savings in excess of $280M since its inception in 2012/13. This, combined with good financial management, saw the DHB generate surpluses for several years, with the first deficit being realised in 2018/19 as shown in the table below.

	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 Actual $'000	2020/21 Budget $'000	2020/21 Forecast $'000
Net Surplus/(Deficit)	154	264	355	2,872	3,162	1,013	(231,968)	(103,767)	(45,043)	(96,229)

The deficits in 2018/19 and 2019/20 are primarily due to extraordinary items, mainly a provision for staff liabilities for non-compliance with the Holidays Act (the provision was $219M in 2018/19 and increased to $279M at 30 June 2020). Each year, the provision needs to be increased as the liability will continue to grow until the remediation programme is completed and payroll systems are updated to comply with the Holidays Act. Auckland DHB worked jointly with the two other Metro Auckland DHBs to engage a remediation partner and to implement the remediation and rectification programme over the next 24 months. Other extraordinary factors affecting the DHB results include staff liabilities that have to be valued actuarially (e.g. retiring gratuities) and the unfunded COVID-19 impacts. For 2020/21, the $96.229M deficit includes a Holidays Act liability increase impact of $39.7M and unfunded Covid Impact of $14.7M, leaving the underlying business as usual operational result favourable to budget at $41.8M (which is favourable to the approved deficit of $45M).

Financial Sustainability

We have lived within our means in the past and plan to return to that position by:

- Containing cost growth through process and system improvements, contracting, procurement, cash management, revenue maximisation, staffing mix strategies and various one-off savings.
- Developing and prioritising programmes to deliver the best health service and outcomes for the local, regional and national population that we serve.
- Aligning investments, programmes and projects to our vision for **Healthy communities - World-class healthcare - Achieved together** in order to deliver strategic change across the continuum of services we provide (primary, secondary and tertiary).
- Fostering 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.
- Creating an environment of continuous improvement and innovation in processes, systems and the way services are delivered while also living our organisational values and delivering the best care for our patients, clients and customers.
- Working regionally, sharing ideas and information to resolve common including savings opportunities, service changes, and various initiatives to improve our investment management maturity.
- 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. Our Northern Region Long Term Investment Plan (NRLTIP) 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.

Auckland DHB is at the peak of its investment life cycle, requiring significant investments in capacity, condition, compliance and functionality risks inherent in the current asset base. Crown funding support is required to support the investment programme. The main strategic programmes and projects already approved or requiring Crown funding include:

1. **Facilities Infrastructure Remediation Programme (FIRP) ($1B).** The programme, developed based on comprehensive risk assessment, addresses significant risks of ageing critical infrastructure, the need to increase resilience and enable future facility capacity expansion for our hospital campuses. Tranche One ($305M) and Tranche 2 ($262M) business cases were approved by the Minister and are under implementation.
2. **Building for the Future Programme (BFTF) ($1.3B).** The programme is being developed to be implemented in tranches to deliver additional DHB capacity for clinical and support services for at least ten years, in line with capacity requirements outlined in the NRLTIP. There is increasing pressure on resources for most health services, with shortfalls projected in inpatient acute beds, operating and interventional rooms, diagnostic suites, cancer care and critical care. An Integrated Stroke Unit (Ward 51) costing $30M recently completed under the BFTF programme will deliver additional capacity in the short term. Other tranche business cases are being developed to increase operating theatre and bed capacity in the medium term and an Integrated Cancer Services business case is being developed.
3. **Auckland DHB's PICU/ICU Child Health Expansion ($40M):** This is a BFTF Tranche project 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 project was approved by the Minister in December 2020 and will be financed by Crown Equity ($25M) and Starship Foundation donation ($15M).
4. **Hospital Administration System Replacement Programme (HARP) ($55M).** The programme, developed after a comprehensive risk assessment of our clinical and business applications and systems, will replace the antiquated Patient Administration System. HARP is one of the strategic projects prioritised in the ISSP and NRLTIP. Crown funding of $20M was approved to be financed from the Crown and the balance of $35M will be financed by the DHB.

In addition to contributing funds to the strategic projects noted above, we also invest internally generated cash in replacing baseline assets, technology and facility upgrades and refurbishments. Our asset management plans indicate a significant bow wave of deferred clinical and facility assets. The bow wave is in part due to prioritisation of internally generated cash to meet capital needs not only for baseline asset renewals, but also for capacity increase, technology improvement and to address quality and compliance issues.

Our capital programme is exerting more financial pressure on our bottom-line and long term sustainability. We will continue to work with our regional counterparts and nationally on service development and investment planning to address our capacity gaps, deliver better outcomes for our population, ensure investment decisions are robust, reduce duplication of services and, ensure joined planning for resources we compete for (e.g. workforce, contractors, funding).

Financial Planning Setting

The DHB is committed to the Government's priorities and delivering high quality services sustainably. This includes living within our means, which is a challenge in the current fiscally constrained environment when the DHB is also experiencing growth in demand, price and volume driven inflation and significant operational impacts of capital programmes. The recent change in the DHB's future funding profile (since 2020/21) is exacerbating the situation. The revised DHB population data has resulted in the DHB being considered overfunded and being placed in a transitional funding pool by the Ministry. This means that the DHB will not be receiving additional demographic growth funding until the transitional funding of $106M is back in parity with the PBFF model. This equates to about $30M of lost revenue increase each year over the next 3 to 4 years. While funding growth is slowing, the expenditure growth trajectory continues unabated. Part of our out-year deficits in the plan a result of this and an acknowledgement that 'low hanging fruit' in the savings programme have been exhausted and radical changes are required to remain financially sustainable.

A partial correction of the previous cost/price anomaly implemented in 2020/21 through a national price uplift assisted in addressing a systemic issue relating to the national prices not fully reflecting the true cost of providing services. Funding

advised for the balance is now lower than anticipated as implementation of the price adjustor has been changed to 75% only, instead of full implementation in 2020/21.

We will continue to work with central agencies and other DHBs 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 will also 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 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. Key revenue assumptions for the financial projections are summarised below:

- Funding for 2021/22 was budgeted as per the Ministry of Health funding advice.
- No demographic growth funding is assumed as Auckland DHB is in the transitional funding pool, with demographic growth funding only expected in 2024/25.
- 2021/22 additional underlying Cost Pressure has been implemented at 75% as per Ministry advice, leaving a significant funding gap for the DHB.
- Planned Care funding was budgeted as advised by the Ministry with associated planned volumes.
- Ministry of Health funding contracts and Crown Funding Agreement Variations (outside of the FE advice) that end in 2020/21 were assumed to roll over and included in the 2021/22 Budget with funding budgeted as advised by the Ministry and with associated expenditure.
- IDF Inflows were budgeted based on Ministry of Health funding advice and any known changes to contract volumes per the Price Volume Schedule.
- We budgeted for the annual increase in the provision for the liability for non-compliance with Holidays Act ($40M per year). Per Ministry of Health advice, we have not included the funding to fully offset this, resulting in a $40M deficit impact in each of the planning years. As this is an additional cost pressure not previously reflected in pricing, and in line with the understanding of the Holidays Act liability, it is anticipated that the cash required to remediate the non-compliance will be funded by the Crown.
- We budgeted for COVID-19 based on the Ministry's funding advice, with funding advised expected to be fully offset by expenditure. COVID-19 budget is only in the Funder and Public Health service with no budget provisioned in the Provider (other than Public Health). As such, it is assumed that any additional COVID-19 impacts outside of the funding will impact the bottom line.
- All other funding is based on contracts or estimated uplifts/reductions based on historical analysis.
- We revalued the DHB's land assets at 30 June 2021, resulting in an increase in value of $44.837M. This will result in an increase in an increase in capital charge and we assumed revenue to fully offset this impact.
- Any capital charge increases relating to major capital 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. The impact of strategic projects approved by the Minister of Health were included and those not yet approved were not included.
- This plan assumes that the impact of strike action (if any) on the DHB's ability to deliver Elective volumes and IDFs 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. No revenue was assumed for this in the plan.

Expenditure Growth

The following assumptions were made relating to expenditure in the four year financial plans:

- Salary increases for settled MECAs were budgeted at settlement levels. Salary growth for unsettled MECAs were budgeted at a base increase of 1.9% plus relevant allowances for other costs, such as step increases, kiwi saver, annualisation of personnel costs that came through part year, including CCDM etc. Any settlements greater than this level are not affordable to the DHB and will have a bottom-line impact if not fully funded. There is a risk that any settlement reached above these parameters will negatively impact on the projected deficit for 2021/22. Additionally, any extra costs in relation to managing ongoing industrial action was not factored into the projected expenditure.
- Personnel costs include an increase in the provision for the Holidays Act liability in each year, estimated at $40M per year.
- As the DHB has no demographic growth funding, FTE growth was limited to essential increases only for approved areas, which mainly include CCDM, Care Navigation, COVID-10, capacity related and compliance driven. There is a substantial financial risk that the expected volume growth of over 5% will be able to be managed from within existing resources based solely on delivered productivity improvement initiatives.
- Clinical supplies cost growth reflects inflation factor in current contracts, estimation of price change on supplies, and adjustments for known specific information within services. 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. There is a significant risk related to clinical supplies, limited cost growth which has been included in the savings plan, this could materialise depending on supply chain related price pressures or volume demand
- Infrastructure cost growth (excluding interest, depreciation and capital charge) is based on the actual known inflation factor per contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. A budget risk relating to depreciation has been assumed based on considerations for timing and capacity to implement projects. This will be managed as part of the savings programme.
- Interest expense is based on asset leasing arrangements. Capital charge reflects the estimated Crown equity position (including asset revaluation impact) at balance date at 5% capital charge rate.
- Depreciation is based on the fixed asset register and anticipated capitalisations from the planned capital expenditure. Depreciation for approved strategic projects, such as FIRP, was included based on expected capitalisation profiles for the projects.
- Extraordinary costs in relation to additional cyber security resilience measures, in light of recent Health sector cyber events, have not been included in our expenditure projections, and would materially impact our ability to achieve the forecast deficit if not otherwise funded.
- COVID-19 impacts were included in Funder expenditure lines and Auckland Regional Public Health Services, with corresponding offsetting Ministry funding. No provision for COVID-19 expenditure was made for Provider operational areas, and any unfunded COVID-19 impacts will have an impact on the bottom line.
- A full revaluation of land was completed as part of 2020/21 year end and the impact of this was included in the financial accounts. It is assumed that the increase in capital charge expense will be fully offset by additional Crown.
- 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.
- We are committed to continuing the savings programme to delivery $39M savings from the following initiatives incorporated in the budget: productivity gains, cost containment, personnel management, supply chain improvements and revenue growth. We will continue to develop further initiatives in order to mitigate risk associated with delivery of these savings plans, however are cognisant that there may be limited ability to alleviate all of the potential risk inherent on the financial forecasts without compromising service provision.

Financial Risks

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

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. DHB expenditure is very sensitive to changes in the cost of settlement of MECAs. Any 1% change in personnel costs for Auckland DHB equates to $13M (2020/21 cost).

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. In 2019/20 and 2020/21, COVID-19 has had a significant impact on the ability to meet IDF and Planned care volume contracts.

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. This ability has deteriorated significantly with the DHB being placed in transitional funding and not receiving 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.

Impact of Strikes, COVID-19 future waves and any other communicable disease outbreaks

Ongoing disruption and additional costs of COVID-19 exert more pressure on DHB resources and ability to remain sustainable. With the DHB in transitional funding and not receiving any demographic growth funding, there is no capacity to absorb any shocks from COVID-19 or other factors.

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 2021/22 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 Draft forecast financial statements for the period 2021/22 to 2024/25 included in this Annual Plan are authorised by the Board of Directors on 1 September 2021.

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 2019/20, financial forecast for 2020/21 and, financial plans for years 2021/22 to 2024/25. The DHB has not as yet received funding indications regarding PBFF uplift or cost pressures for 2021/22, which gives uncertainty of revenue elements and some

aspects of cost; therefore, this plan was prepared to reflect expected costs at a high level and limited reliance should be placed on the financial projections included in it.

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.

The Statement of Comprehensive Revenue and Expenses for the Group and the Parent are presented in a manner that shows clearly the breakeven position for BAU and the impact of the extraordinary items. The rest of the financial statements is presented including the extraordinary item (Holiday Act liability increase).

Statement of Comprehensive Revenue and Expenses – Group

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,688,523	1,812,322	1,935,831	2,022,421	2,062,328	2,103,027
Non-Government & Crown Agency Sourced	106,934	104,775	101,508	101,508	101,508	101,508
IDFs & Inter-DHB Sourced	701,179	762,699	812,064	827,937	844,129	860,643
TOTAL FUNDING	**2,496,636**	**2,679,796**	**2,849,403**	**2,951,867**	**3,007,965**	**3,065,179**
EXPENDITURE						
Personnel Costs	1,211,109	1,265,567	1,307,405	1,332,766	1,359,421	1,386,609
Outsourced Costs	155,094	181,283	162,435	164,989	168,289	171,655
Clinical Supplies Costs	312,320	333,615	349,726	353,440	358,750	364,139
Infrastructure & Non-Clinical Supplies Costs	219,566	230,551	217,497	221,532	223,982	226,502
Payments to Providers	599,022	660,241	768,473	797,811	813,768	830,043
IDF Outflows	103,143	104,768	116,867	121,329	123,755	126,230
TOTAL EXPENDITURE	**2,600,253**	**2,776,025**	**2,922,403**	**2,991,867**	**3,047,965**	**3,105,179**
Share of associate joint venture surplus/(deficit)	**(150)**	**-**	**-**	**-**	**-**	**-**
NET Surplus/(Deficit)	**(103,767)**	**(96,229)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(DEFICIT)	**(103,767)**	**(51,393)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**

The net surplus/(deficits) shown above comprises deficits from an extraordinary item for the Holidays Act liability, unfunded COVID-19 impacts, and underlying business as usual operations as summarised in the table below.

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Holidays Act Liability increase	(60,768)	(39,731)	(40,000)	(40,000)	(40,000)	(40,000)
Business as usual	(16,657)	(41,780)	(33,000)			
Unfunded COVID-19 Impacts	(26,342)	(14,718)				

Statement of Comprehensive Revenue and Expenses – Parent

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
FUNDING						
Government & Crown Agency Sourced	1,688,523	1,812,322	1,935,831	2,022,421	2,062,328	2,103,027
Non-Government & Crown Agency Sourced	106,110	99,583	96,324	96,324	96,324	96,324
IDFs & Inter-DHB Sourced	701,179	762,699	812,064	827,937	844,129	860,643
TOTAL FUNDING	**2,495,712**	**2,674,604**	**2,844,219**	**2,946,683**	**3,002,781**	**3,059,995**
EXPENDITURE						
Personnel Costs	1,210,527	1,265,013	1,306,850	1,332,211	1,358,866	1,386,054
Outsourced Costs	155,094	181,283	162,435	164,989	168,289	171,655
Clinical Supplies Costs	312,320	333,615	349,726	353,440	358,750	364,139
Infrastructure & Non-Clinical Supplies Costs	219,815	227,575	214,530	218,565	221,015	223,535
Payments to Providers	599,022	660,241	768,473	797,811	813,768	830,043
IDF Outflows	103,143	104,768	116,867	121,329	123,755	126,230
TOTAL EXPENDITURE	**2,599,920**	**2,772,495**	**2,918,881**	**2,988,345**	**3,044,443**	**3,101,657**
NET Surplus/(Deficit)	**(104,208)**	**(97,891)**	**(74,662)**	**(41,662)**	**(41,662)**	**(41,662)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
TOTAL COMPREHENSIVE INCOME/(DEFICIT)	**(104,208)**	**(53,055)**	**(74,662)**	**(41,662)**	**(41,662)**	**(41,662)**

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.

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
FINANCING COSTS						
Interest	562	704	1,201	1,201	1,201	1,201
Depreciation	55,495	59,045	65,874	71,432	82,574	96,222
Capital Charge	45,993	33,661	34,793	39,408	47,736	51,256
TOTAL FINANCING COSTS	**102,050**	**93,410**	**101,868**	**112,041**	**131,512**	**148,679**
% of Infrastructure & Non Clinical Supply Costs	**47%**	**41%**	**47%**	**51%**	**59%**	**66%**

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.

Statement of Cashflows – Group

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
Cash receipts from MoH and patients	2,380,642	2,589,290	2,747,895	2,850,359	2,906,457	2,963,671
Other receipts	101,487	102,342	98,883	98,883	98,883	98,883
	2,482,129	**2,691,632**	**2,846,778**	**2,949,242**	**3,005,340**	**3,062,554**
Cash was applied to						
Cash paid to employees	(1,095,334)	(1,173,328)	(1,227,405)	(1,292,766)	(1,319,421)	(1,346,609)
Cash paid to suppliers	(1,279,967)	(1,396,930)	(1,514,331)	(1,548,262)	(1,558,233)	(1,571,092)
Net GST Paid	3,842	(1,813)	-	-	-	-
Payments for Capital Charge	(45,993)	(33,661)	(34,793)	(39,408)	(47,736)	(51,256)
	(2,417,452)	**(2,605,732)**	**(2,776,528)**	**(2,880,435)**	**(2,925,391)**	**(2,968,957)**
NET CASHFLOW FROM OPERATING ACTIVITIES	**64,677**	**85,900**	**70,249**	**68,806**	**79,949**	**93,597**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	4,159	2,408	2,625	2,625	2,625	2,625
Proceeds from Sale of property, plant & equipment	162	25	-	-	-	-
Decrease/(Increase) in Investments & restricted trust funds	11,731	19,080	-	-	-	-
	16,052	**21,513**	**2,625**	**2,625**	**2,625**	**2,625**
Cash was applied to						
Purchase of property, plant & equipment	(68,091)	(87,873)	(259,420)	(276,182)	(198,111)	(80,275)
Purchase of intangible assets	(2,313)	(2,040)	(26,672)	(26,122)	(27,258)	(11,584)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(54,352)**	**(68,400)**	**(283,467)**	**(299,679)**	**(222,744)**	**(89,234)**
FINANCING ACTIVITIES						
Interest paid	(562)	(704)	(1,201)	(1,201)	(1,201)	(1,201)
Repayment of loans	(1,544)	(97)	(98)	-	-	-
Proceeds of borrowings	3,444	4,911	6,225	(3,134)	(3,142)	(3,134)
Proceeds from capital contributed/(repaid)	30,047	44,957	131,752	208,198	153,128	25,660
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**31,385**	**49,067**	**136,678**	**203,863**	**148,973**	**21,325**
NET CASH INFLOW/(OUTFLOW)	**41,710**	**66,568**	**(76,540)**	**(27,009)**	**5,998**	**25,688**
Cash & cash equivalents at the start of the year	**94,192**	**135,902**	**202,469**	**125,928**	**98,919**	**104,917**
Cash & cash equivalents at the end of the year	**135,902**	**202,469**	**125,928**	**98,919**	**104,917**	**130,605**

The increasing operating cashflow over the years reflects the impact of the cash for the Holidays Act remediation assumed to be received, to offset the increase in the provision each year.

Statement of Cashflows – Parent

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
CASHFLOW FROM OPERATING ACTIVITIES						
Cash was provided from						
Cash receipts from MoH and patients	2,380,642	2,589,290	2,747,895	2,850,359	2,906,457	2,963,671
Other receipts	94,994	94,439	93,699	93,699	93,699	93,699
Total operating cash receipts	**2,475,636**	**2,683,729**	**2,841,594**	**2,944,058**	**3,000,156**	**3,057,370**
Cash was applied to						
Cash paid to employees	(1,094,808)	(1,172,774)	(1,226,850)	(1,292,211)	(1,318,866)	(1,346,054)
Cash paid to suppliers	(1,278,318)	(1,395,730)	(1,511,364)	(1,545,295)	(1,555,266)	(1,568,125)
Net GST Paid	3,731	(2,094)	-	-	-	-
Payments for Capital Charge	(45,993)	(33,661)	(34,793)	(39,408)	(47,736)	(51,256)
Total operating Cash payments	**(2,415,388)**	**(2,604,259)**	**(2,773,006)**	**(2,876,913)**	**(2,921,869)**	**(2,965,435)**
NET CASHFLOW FROM OPERATING ACTIVITIES	**60,248**	**79,471**	**68,587**	**67,144**	**78,287**	**91,935**
INVESTING ACTIVITIES						
Cash was provided from						
Interest Received	3,743	2,237	2,625	2,625	2,625	2,625
Proceeds from property, plant & equipment	162	25	-	-	-	-
Decrease/(Increase) in Investments & restricted trust funds	10,379	19,080	-	-	-	-
	14,284	**21,112**	**2,625**	**2,625**	**2,625**	**2,625**
Cash was applied to						
Purchase of property, plant & equipment	(68,039)	(87,873)	(259,420)	(276,182)	(198,111)	(80,275)
Purchase of intangible assets	(2,313)	(2,040)	(26,672)	(26,122)	(27,258)	(11,584)
NET CASH (OUTFLOW) FROM INVESTING ACTIVITIES	**(56,068)**	**(68,801)**	**(283,467)**	**(299,679)**	**(222,744)**	**(89,234)**
FINANCING ACTIVITIES						
Interest paid	(562)	(704)	(1,201)	(1,201)	(1,201)	(1,201)
Repayment of loans	(1,544)	(97)	(98)	-	-	-
Proceeds of borrowings	3,444	4,911	6,225	(3,134)	(3,142)	(3,134)
Proceeds from capital contributed/(repaid)	30,047	44,957	131,752	208,198	153,128	25,660
NET CASH (OUTFLOW) FROM FINANCING ACTIVITIES	**31,385**	**49,067**	**136,678**	**203,863**	**148,793**	**21,325**
NET CASH INFLOW/(OUTFLOW)	**35,565**	**56,974**	**(78,202)**	**(28,671)**	**4,336**	**24,026**
Cash & cash equivalents at the start of the year	**94,192**	**129,757**	**189,493**	**119,290**	**86,619**	**86,955**
Cash & cash equivalents at the end of the year	**129,757**	**189,493**	**111,290**	**86,619**	**86,955**	**110,981**

Statement of Financial Position – Group

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	135,902	202,469	125,928	98,919	104,917	130,605
Investments	15,000	-	-	-	-	-
Trust/special funds	15,018	9,297	9,297	9,297	9,297	9,297
Restricted trust funds	1,376	1,410	1,410	1,410	1,410	1,410
Debtors & other receivables	111,917	121,311	121,311	121,311	121,311	121,311
Prepayments	4,622	5,920	5,216	4,511	3,807	3,102
Inventories	15,396	16,275	16,275	16,275	16,275	16,275
Total Current Assets	**299,231**	**356,682**	**279,437**	**251,723**	**257,017**	**282,001**
Non-current assets						
Investments	-	-	-	-	-	-
Trust/special funds	15,970	17,577	17,577	17,577	17,577	17,577
Property, Plant and Equipment	1,131,133	1,206,860	1,378,277	1,610,398	1,756,373	1,760,506
Intangible Assets	9,300	10,046	20,753	20,942	19,671	13,080
Investment in joint ventures & associates	75,057	79,676	79,676	79,676	79,676	79,676
Total Non-Current Assets	**1,231,460**	**1,314,159**	**1,496,283**	**1,728,593**	**1,873,297**	**1,870,839**
TOTAL ASSETS	**1,530,691**	**1,670,841**	**1,775,719**	**1,980,316**	**2,130,313**	**2,152,840**
LIABILITIES						
Current liabilities						
Payables and deferred revenue	195,411	242,602	242,602	242,233	242,233	242,233
Employee benefits	505,323	595,625	635,625	675,625	715,625	755,625
Provisions	1,742	1,661	1,661	1,661	1,661	1,661
Borrowings	1,925	2,828	2,828	2,728	2,728	2,728
Restricted trust funds	1,384	1,410	1,410	1,410	1,410	1,410
Total Current Liabilities	**705,785**	**844,126**	**884,126**	**923,657**	**963,657**	**1,003,657**
Non-current liabilities						
Employee Benefits	88,932	93,268	93,268	93,268	93,268	93,268
Borrowings	10,136	14,047	20,174	17,040	13,907	10,773
Total Non-Current Liabilities	**99,068**	**107,315**	**113,442**	**110,308**	**107,175**	**104,041**
TOTAL LIABILITIES	**804,853**	**951,441**	**997,568**	**1,033,965**	**1,070,832**	**1,107,698**
EQUITY						
Contributed Capital	919,427	964,379	1,096,134	1,304,330	1,457,461	1,483,121
Accumulated surplus/(deficit)	(821,488)	(919,378)	(994,043)	(1,035,703)	(1,077,364)	(1,119,027)
Property revaluation reserve	599,151	643,988	643,988	643,988	643,988	643,988
Trust/special funds	28,748	30,411	32,073	33,735	35,397	37,059
TOTAL EQUITY	**725,838**	**719,400**	**778,152**	**946,350**	**1,059,482**	**1,045,141**
NET ASSETS	**725,838**	**719,400**	**778,152**	**946,350**	**1,059,482**	**1,045,141**

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 deficits.

Statement of Financial Position – Parent

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
ASSETS						
Current assets						
Cash and cash equivalents	129,757	189,493	111,290	82,619	86,955	110,981
Investments	15,000	-	-	-	-	-
Trust/special funds	-	-	-	-	-	-
Restricted trust funds	1,376	1,410	1,410	1,410	1,410	1,410
Debtors & other receivables	114,127	118,477	118,477	118,477	118,477	118,477
Prepayments	4,622	5,920	5,216	4,511	3,807	3,102
Inventories	15,396	16,275	16,275	16,275	16,275	16,275
Total Current Assets	**280,278**	**331,575**	**252,668**	**223,292**	**226,924**	**250,246**
Non-current assets						
Investments	-	-	-	-	-	-
Trust/special funds	-	-	-	-	-	-
Property, Plant and Equipment	1,130,141	1,205,344	1,376,763	1,608,883	1,754,860	1,758,993
Intangible Assets	9,300	10,046	20,753	20,942	19,671	13,080
Investment in joint ventures & associates	74,539	79,058	79,058	79,058	79,058	79,058
Total Non-Current Assets	**1,213,980**	**1,294,448**	**1,476,574**	**1,708,883**	**1,853,589**	**1,851,131**
TOTAL ASSETS	**1,494,258**	**1,626,023**	**1,729,241**	**1,932,175**	**2,080,512**	**2,101,377**
LIABILITIES						
Current liabilities						
Payables and deferred revenue	188,429	228,894	228,894	228,525	228,525	228,525
Employee benefits	505,240	595,542	635,542	675,542	715,542	755,542
Provisions	1,742	1,661	1,661	1,661	1,661	1,661
Borrowings	1,925	2,828	2,828	2,728	2,728	2,728
Restricted trust funds	1,384	1,410	1,410	1,410	1,410	1,410
Total Current Liabilities	**698,720**	**830,335**	**870,335**	**909,866**	**949,866**	**989,866**
Non-current liabilities						
Employee Benefits	88,932	93,268	93,268	93,268	93,268	93,268
Borrowings	10,136	14,047	20,174	17,040	13,907	10,773
Total Non-Current Liabilities	**99,068**	**107,315**	**113,442**	**110,308**	**107,175**	**104,041**
TOTAL LIABILITIES	**797,788**	**937,650**	**983,777**	**1,020,174**	**1,057,041**	**1,093,907**
EQUITY						
Contributed Capital	919,427	964,384	1,096,138	1,304,336	1,457,469	1,483,129
Accumulated surplus/(deficit)	(822,108)	(919,999)	(994,661)	(1,036,324)	(1,077,985)	(1,119,648)
Property revaluation reserve	599,150	643,988	643,988	643,988	643,988	643,988
Trust/special funds	-	-	-	-	-	-
TOTAL EQUITY	**696,470**	**688,373**	**745,465**	**912,000**	**1,023,472**	**1,007,469**
NET ASSETS	**696,470**	**688,373**	**745,465**	**912,000**	**1,023,472**	**1,007,469**

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

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
BALANCE AT 1 JULY	**799,558**	**725,838**	**719,400**	**778,152**	**946,350**	**1,059,482**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	(103,767)	(96,229)	(73,000)	(40,000)	(40,000)	(40,000)
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
Other movements	-	(3)	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(103,767)**	**(51,395)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	30,047	44,957	131,752	208,199	153,131	25,660
BALANCE AT 30 JUNE	**725,838**	**719,400**	**778,152**	**946,350**	**1,059,482**	**1,045,141**

Statement of Changes in Net Assets/Equity – Parent

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
BALANCE AT 1 JULY	**770,631**	**696,470**	**688,373**	**745,463**	**912,000**	**1,023,470**
Comprehensive Income/(Expense)						
Surplus/Deficit for the Year	(104,208)	(97,891)	(74,662)	(41,662)	(41,662)	(41,662)
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
Other movements	-	1	3	-	-	-
TOTAL COMPREHENSIVE INCOME	**(104,208)**	**(53,054)**	**(74,662)**	**(41,662)**	**(41,662)**	**(41,662)**
OWNER TRANSACTIONS						
Capital Contributions from the Crown	30,047	44,957	131,752	208,199	153,131	25,660
BALANCE AT 30 JUNE	**696,470**	**688,373**	**745,463**	**912,000**	**1,023,470**	**1,007,467**

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

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
REVENUE						
Government & Crown Agency Sourced	1,563,530	1,663,697	1,794,322	1,877,438	1,914,987	1,953,286
Non-Government & Crown Agency Sourced	11,409	10,272	10,272	10,477	10,687	10,901
IDFs & Inter-DHB Sourced	686,267	733,031	793,595	809,467	825,656	842,169
TOTAL REVENUE	**2,261,206**	**2,407,000**	**2,598,189**	**2,697,382**	**2,751,330**	**2,806,356**
EXPENDITURE						
Payment to Provider	1,478,645	1,593,174	1,696,453	1,761,220	1,796,444	1,832,373
Payment to Governance	15,323	15,758	16,396	17,022	17,362	17,710
Total Payments to Internal Provider	**1,493,968**	**1,608,932**	**1,712,849**	**1,778,242**	**1,813,807**	**1,850,083**
NGO Expenditure						
Personal Health	354,491	392,933	406,519	422,039	430,480	439,089
Mental Health	42,897	66,149	67,171	69,735	71,130	72,553
DSS	177,108	171,170	208,224	216,174	220,497	224,907
Public Health	22,960	28,677	84,954	88,197	89,961	91,761
Māori Health	1,568	1,312	1,605	1,666	1,700	1,734
Total Payments to NGO providers	**599,024**	**660,241**	**768,473**	**797,811**	**813,768**	**830,043**
IDF Outflows	103,143	104,768	116,867	121,329	123,755	126,230
Total Payments to External Providers	**702,167**	**765,009**	**885,340**	**919,140**	**937,523**	**956,273**
TOTAL EXPENDITURE	**2,196,135**	**2,373,941**	**2,598,189**	**2,697,382**	**2,751,330**	**2,806,356**
SURPLUS/(DEFICIT)	**65,071**	**33,059**	**-**	**-**	**-**	**-**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME	**65,071**	**33,059**	**-**	**-**	**-**	**-**

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.

Provider Arm Financial Performance

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
INCOME						
MoH Base via Funder	1,493,558	1,622,702	1,714,836	1,779,603	1,814,827	1,850,756
MoH Direct	64,514	86,685	82,259	84,911	86,434	87,985
Other	155,153	156,215	150,486	151,103	151,729	152,363
TOTAL INCOME	**1,713,225**	**1,865,602**	**1,947,581**	**2,015,617**	**2,052,990**	**2,091,104**
EXPENDITURE						
Personnel	1,206,480	1,260,947	1,302,959	1,328,250	1,354,815	1,381,911
Outsourced Services	139,681	164,390	146,856	149,177	152,160	155,203
Clinical Supplies	312,082	333,306	349,566	353,279	358,586	363,972
Infrastructure & non clinical supplies	217,735	226,534	212,766	216,478	218,994	221,583
Other	7,825	9,655	8,434	8,434	8,434	8,434
TOTAL EXPENDITURE	**1,883,803**	**1,994,832**	**2,020,581**	**2,055,617**	**2,092,990**	**2,131,105**
SURPLUS/(DEFICIT)	**(170,578)**	**(132,035)**	**(74,921)**	**(40,000)**	**(40,000)**	**(40,000)**
Other Comprehensive Income						
Gains/(Losses) on Property Revaluations	-	44,837	-	-	-	-
TOTAL COMPREHENSIVE INCOME	**(170,578)**	**(84,393)**	**(73,000)**	**(40,000)**	**(40,000)**	**(40,000)**

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. COVID-19 impacts on provider arm resources also has implications for the ability to deliver to planned care and IDF volume contracts. The impacts of the significant investment programme fall on the provider arm, and without new demographic growth funding, the ability to absorb additional costs is limited. The DHB will continue working on the internal issues to improve productivity, improve processes and contain cost growth within controllable areas. However, the DHB will also need to work with the central agency and other DHBs to consider radical shifts in how services are delivered and the levels of service that should be delivered within the available funding.

Governance and Funding Administration Arm Financial Performance

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Revenue from Funder Arm	15,323	15,898	16,482	17,110	17,452	17,801
Revenue Other	700	228	-	-	-	-
TOTAL INCOME	**16,023**	**16,126**	**16,482**	**17,110**	**17,452**	**17,801**
EXPENDITURE	**14,282**	16,184	16,482	17,110	17,452	17,801
SURPLUS/(DEFICIT)	**1,741**	**(58)**	**-**	**-**	**-**	**-**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME	**1,741**	**(58)**	**-**	**-**	**-**	**-**

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

Capital Expenditure

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. Only projects that have been approved by the Minister have been included in the plans i.e. FIRP Tranches 1 & 2, BFTF PICU, BFTF Ward 51. Projects where funding has been requested from the Ministry but not yet approved have not been included. The financials indicate that the HARP project can be accommodated into the plans.

	2019/20 Audited $'000	2020/21 Forecast $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
FINANCING SOURCES						
Free cashflow from depreciation	55,495	59,045	65,874	71,432	82,574	96,222
External Crown Funding	30,047	44,957	131,752	208,199	153,129	25,660
Private Funding - Finance leases	1,900	4,911	6,225	(3,134)	(3.142)	(3,134)
Donations	-	-	6,663	7,552	-	-
Cash Reserves	(23,195)	(19,000)	75,578	18,255	(7,200)	(26,890)
TOTAL FINANCING	**64,246**	**89,913**	**286,092**	**302,304**	**225,369**	**91,859**
BASELINE CAPITAL EXPENDITURE						
Land	1,000	5,131	-	-	-	-
Buildings and Plant	15,692	9,490	27,152	32,400	32,400	32,400
Clinical Equipment	21,333	22,773	57,388	24,000	24,000	24,000
Other Equipment	1,496	1,506	8,316	600	600	600
Information Technology (Hardware)	323	1,001	2,700	2,000	2,000	2,000
Intangible Assets (Software)	477	2,040	21,859	6,000	6,000	6,000
Motor Vehicles	779	195	809	1,000	1,000	1,000
TOTAL BASELINE CAPITAL EXPENDITURE	**41,100**	**42,136**	**118,223**	**66,000**	**66,000**	**66,000**
STRATEGIC INVESTMENTS						
Land	-	-	-	-	-	-
Buildings & Plant	21,828	47,629	160,556	213,682	133,111	20,275
Clinical Equipment		-	2,500	2,500	5,000	-
Other equipment	-	-	-	-	-	-
Information Technology (Hardware)	-	148	-	-	-	-
Intangible Assets (Software)	1,318	-	4,813	20,122	21,258	5,584
Motor Vehicles	-	-	-	-	-	-
TOTAL STRATEGIC CAPITAL EXPENDITURE	**23,146**	**47,777**	**167,869**	**236,304**	**159,369**	**25,859**
TOTAL CAPITAL PAYMENTS	**64,246**	**89,913**	**286,092**	**302,304**	**225,369**	**91,859**

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 (DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. 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.

The forecast financial statements of Auckland DHB comprise 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, Auckland DHB Charitable Trust and Auckland Health Foundation. Joint ventures are healthAlliance N.Z. Limited (25%) and HealthSource NZ Limited (40%). Associates are Northern Regional Alliance Limited (33.3%). The DHB's subsidiaries, associates and joint ventures are incorporated and domiciled in New Zealand.

Auckland DHB's activities include delivering health and disability services through its internal provider arm, shared services including Funding and Planning administration, as well as funding services purchased from external providers (e.g. from non-governmental organisations and other community services). The group's primary objective is to deliver health, disability, and mental health services to the community within its district as well as to deliver regional and national services. The group does not operate to make a financial return. The group is designated as a public benefit entity (PBE) for the purposes of complying with generally accepted accounting practice.

Basis of preparation

Health sector reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 District Health Boards (DHBs) with a new Crown entity, Health New Zealand, that will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms, the financial forecasts of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these financial forecasts, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

Operating and cash flow forecasts

Operating and cash flow forecasts indicate that the DHB will have sufficient funds (including equity funding from the Crown for approved capital projects) to meet the forecast operating and investing cash flow requirements of the DHB for the 2021/22 financial year. However, if the DHB is required to settle the holiday pay liability prior to 1 July 2022, additional financial support would be needed from the Crown.

Letter of comfort

The Board has requested a letter of comfort from the Ministers of Health and Finance. The letter of comfort will state that the Government is committed to working with the DHB to maintain its financial viability and acknowledges that, if required over the period up until Health New Zealand is established, the Crown will provide equity support where necessary to maintain viability.

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.

Changes in Accounting Policies

Standards issued that are not yet effective and that have not been 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 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 9.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Auckland DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

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 so as 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 DHB's 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 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 dollars (the functional currency) using the exchange rates prevailing 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.

Goods and Services Tax

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

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the Statement of Financial Position.

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

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 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.

Information technology shared services rights
The DHB and group has provided funding for the development of information technology (IT) shared services across the DHB sector and the rights to the shared services is recognised as an intangible asset at the cost of the group's capital investment.

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%)
- FPIM rights 15 years (6.67%).

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. No restructuring provision has been included in the forecast financials in respect to the health sector reforms.

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 2021. The next full revaluation of land and buildings will be completed as at 30 June 2022.

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, 2 Kari Street and 99 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 2019 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 2019 valuation:

- Land market values range from $3,000 to $4,000 per square metre depending on location
- Office market rents range from $245 to $260 per square metre
- Capitalisation rates are market-based rates of return and range from 3.00% to 7.50%.

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 used is 68 years, with 20% probability of early retirement at each age from 65 to 67 years.

Continuing Medical Education Leave
The continuing medical education leave liability assumes the utilisation of the annual entitlement based on recent experience. However, due to the impacts of COVID-19 on travel, this impacts on the ability of staff to attend conferences, etc. Medical staff can now carry forward their entitlements for up to five years.

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.

Auckland DHB is working jointly with the two other Metro Auckland DHBs on a two-year Holidays Act Remediation and Rectification programme, which will result in compliance with the Holidays Act.

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 statement.

APPENDIX C: 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)
	Justine White	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
	Mike Shepherd	Interim Director of Provider Services
	Dr Debbie Holdsworth	Director of Funding
	Dr Karen Bartholomew	Director of Health Outcomes (Auckland, Waitematā DHBs)
	Nigel Chee	General Manager Māori Health (Auckland, Waitematā DHBs)
	Anna Redican	Pacific Equity Programme Manager
Children's Health Directorate	Dr Michael Shepherd	Director
Mental Health and Addictions Directorate	Hineroa Hakiaha, Tracy Silva Garay	Directors
Adult Medical Services Directorate	Dr Barry Snow	Director
Adult Community and Long Term Conditions Directorate	Samantha Titchener	Interim Director
Cancer and Blood Directorate	Dr Richard Sullivan	Director
Perioperative Services Directorate	Dr Nigel Robertson	Director
Surgical Services Directorate	Vacancy	Director
Cardiac Directorate	Dr Mark Edwards	Director
Women's Health Directorate	Angela Beaton	Director
Clinical Support Services Directorate	Ian Costello	Director

APPENDIX D: MINISTER OF HEALTH'S LETTER OF EXPECTATION

The Minister of Health's Letter of Expectations to DHBs is available online:

https://nsfl.health.govt.nz/202122-planning-package-0

APPENDIX E: 2021/22 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Once available, the Metro Auckland DHBs' 2021/22 System Level Measures Improvement Plan will be published online:

https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/slm-improvement-plans