NORTHLAND DISTRICT HEALTH BOARD

Te Poari Hauora Ā Rohe O Te Tai Tokerau

ANNUAL PLAN

2019/20

incorporating

STATEMENT OF PERFORMANCE EXPECTATIONS 2019/20

and

STATEMENT OF INTENT 2019/20-2022/23

Presented to the House of Representatives

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

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

16 DEC 2019

Mr Harry Burkhardt
Chair
Northland District Health Board
harry@replassheet.com

Dear Harry

Northland District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Northland District Health Board's (DHB's) 2019/20 Annual Plan for one year, as submitted by the previous DHB governance.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

The Annual Plan indicates a deteriorating out-years position. I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change

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that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your annual plan.

I would like to thank you, your staff, and your Board for your commitment to delivering quality health care to your population and wish you every success with the implementation of your 2019/20 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

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Part A
Annual Plan

1 Overview of Strategic Priorities

1.1 Strategic intentions and priorities

Vision and mission

Northland DHB's vision: "A Healthier Northland / He Hauora Mo Te Tai Tokerau"

Northland DHB's mission: Achieved by working together in partnership under the Treaty of Waitangi to:

- improve population health and reduce inequities
- improve the patient experience
- live within our means.

Mahi tahi te kaupapa o Te Tiriti o Waitangi he whakarapopoto nga whakaaro o te Whare Tapa Wha me te whakatuturutahi i te tino rangatiratanga te iwi whanui o Te Tai Tokerau.

Northland DHB is developing a strategy that will provide guidance for our own plans as well as those of the rest of the Northland health sector. Embedded within this will be a population health outcomes approach, with outcome statements and high-level measures.

Strategic priorities

A summary of the presentation made to the Ministry of Health on 8 May 2019.

Northland's characteristics	Areas of strong performance	What we are doing in 2019/20
Poverty	Health Targets for smoking maternity, RHK	Contain cost growth
Population growth	Hospital-acquired and healthcare-associated infections	Seamless system
Ageing population	↓ Relative Stay Index	Shift resources upstream
Rurality	SAFER patient flow	Mental health initiatives
High road fatalities	↓ meth demand (with Police)	Ageing in place
High suicide rate	Pregnancy & parenting service	Cross-sectoral collaboration
Challenges	Primary mental health national collaboration	Staff wellbeing
Inequities for Māori	Cross-sectoral work	Strong Board-Iwi relationship
Long term conditions	Suicide prevention	↑ community involvement
Primary capacity and access	Māori community engagement	Stewardship (VfM, QI)
Ageing workforce	Telehealth & mobility	Staff health, safety, wellbeing
Recruitment	CRAB, HRT benchmarking	Population Health Indicators Framework
% Māori workforce	Innovation, Excellence & Improvement Programme	
↑ demand ED, medical	Stewardship (VfM, QI)	
Age of facilities	Clinical governance	
Vaccination rates	Workforce measures	
	Māori training	
	Regional work	
	Neighbourhood Healthcare Homes	
	Health & Social Care Coordination	
	Primary care collaboration → Mahitahi Hauora	
	Integrated Operations Centre	

Commitments

DHBs have a statutory responsibility under the *Treaty of Waitangi* to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Māori, who comprise about a third of our population, suffer most from health and other inequities and we are committed to upholding the three Treaty principles.

Northland DHB is committed to the *New Zealand Health Strategy* and its five themes of people powered, closer to home, value and high performance, one team, and smart system.

Northland DHB is also committed to *He Korowai Oranga* Māori Health Strategy that sets the overarching framework to guide the Government and the health and disability sector to achieve the best outcomes for Māori.

Among DHBs, Northland has one of the highest percentages of older people in our population (in 2018, 19.6% compared with 15.2% nationally) and it is also ageing faster that most other DHBs (by 2028, 25.7% compared with 19.4% nationally). Northland DHB is committed to the *Healthy Ageing Strategy* and its vision that older people live well, age well and have a respectful end of life in age-friendly communities.

Northland DHB is committed to the *UN Convention on the Rights of Persons with Disabilities*, whose purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The New Zealand *Disability Strategy 2016-2026*) also forms part of Northland DHB's disability strategic framework, with service improvements for 2019/20 focussing on accessibility, attitudes, health and wellbeing, and leadership.

Northland DHB is committed to the principles of *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018*, namely:

- respecting Pacific culture
- valuing family and communities
- quality health care
- working together – integration.

1.2 Message from the Chair and Chief Executive

Northland District Health Board will continue to improve the delivery of services and the wellbeing of our population during 2019/20 while living within our means. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints, local strategic goals and the NZ Health Strategy.

The Board maintained a balanced financial position from 2003 till 2017/18 when we had a deficit budget for the first time. For all DHBs finances are becoming an increasing challenge. Through the normal fluctuations of Population Based Funding Northland DHB received $10 million less new revenue for 2019/20 ($26 million compared to $36 million in 2018/19), so our budgeted deficit has increased from $7.5 million to $12.8 million.

Northland DHB has a continuing commitment to improving efficiency and investing upstream to reduce demand for and the cost of expensive hospital care. Significant savings are factored into the plan from our own initiatives, procurement and supply chain savings. We are also committed to a new 'Stewardship' programme as well as strengthening clinical leadership and continuous improvement capability to assist in managing the significant and sustained demand growth. Improving employee wellbeing is one of our major priorities and we have an extensive Wellbeing and leadership programme which is regularly monitored by our Executive leadership Team.

We continue to be challenged by health inequities for Māori. We are investing more in Māori health and have consulted with our communities and are now working with our Māori health providers to review their contracts and look at increased, improved and better value services delivering better health outcomes for Māori. Twenty percent of our population is over 65 (about four percent more than the national average) and it is rapidly ageing. There is a rising tide of long term conditions, and we are challenged by our rurality and the relative poverty of our citizens. We have also seen significant population growth and immigration from Auckland, making Northland easily the fastest growing and the second-largest of the mid-sized DHBs. Obesity is now the greatest avoidable cause of health loss, mortality and inequity. It represents a huge challenge to our sustainability and we will continue to strengthen and align our various programmes with national best practice while advocating for multiparty support for improved national policy and legislation. This latter approach will also extend to alcohol and we intend to work with all DHBs on this over the next year. Our perfect storm of demographic change, immigration and obesity is driving significant growth in demand.

From 1 July 2019 Northland has a single Primary Health Entity, known as Mahitahi Hauora. This enhanced PHO has shared governance and ownership between itself and general practices, Māori health providers and Iwi. Northland DHB's Chief Executive is an ex-officio non voting member of the Board and we have an Alliance agreement with Mahitahi Hauora. It will oversee locality engagement planning and service delivery, have a commissioning role, and will be accountable for agreed outcomes.

A Health and Social Care Coordination programme is underway that aims to integrate the care of patients and their carers, providing access to the right care, at the right time, from the right provider(s) and so improve patient experience, health outcomes and system efficiencies. The programme goals are defined within four interlinked projects, which are at various stages of implementation: the Calderdale Framework, Whānau Tahi, Northland Community Hub and MDT Meeting Standards.

The Neighbourhood Healthcare Homes Project introduces a new model of care within general practice to better manage demand, improve business efficiencies and patient experience. Ten practices are implementing the model from the first two tranches, and work has commenced with a third and final tranche of practices.

The Annual Plan is closely aligned with the Northern Long term Health Plan (an evolution of the Northern Long Term Investment Plan) and its Triple Aim of population health, patient experience and value/sustainability. Relevant regional performance measures have been integrated into the Annual Plan. Regional planning processes, in which Northland DHB staff have been intimately involved, continue to develop models, pathways and protocols to guide future improvement across all four northern DHBs.

Northland DHB is working alongside Mahitahi Hauora to complete a Health Needs Analysis and develop a Northland health strategy. It will need to be cognisant of the Health and Disability System Review and timed for completion once the recommendations of this review are published in about April 2020. The Northland Health Strategy will be a high-level roadmap, cover all health services in Northland, focus on population-level objectives, planning priorities and partnership principles. Over time it will enable medium term (3-5 year) and annual plans within Northland DHB to be aligned, and provide the opportunity for health sector organisations across Northland to align their plans.

Northland DHB continues to work with primary and community services to deliver integrated services for older people to support them living independently in the community, manage long term conditions well and prevent admission to hospital. We are also continuing to improve the quality of residential care services (including dementia care), and stroke services.

Northland DHB works very closely with our intersectoral partners to help improve socioeconomic outcomes for Northlanders. We will continue our membership of the Northland Intersectoral Forum. Northland DHB is Chair of the Social Wellbeing Governance Group which is working on a number of social sector cross-agency priorities. Its aim is to achieve better social outcomes for children and youth. The issues are proving to be complex, involving a range of networks (MSD / Oranga Tamariki, Police, Iwi, Northland DHB, Corrections, Housing, Education and our local district councils) but the group intends to prioritise actions, use data more effectively and build on some of the successes we have had.

Northland DHB plans to undertake a number of works to ensure essential critical capacity is maintained in the medium term, including two new operating theatres, a new endoscopy suite, and a new cardiac catheterisation laboratory. Longer term, a new Whangārei Hospital is needed; the strategic business case was approved in 2017 but in 2018 our Programme Business case was put on hold and we have recently been informed a new Whangārei Hospital could be 15 years away. Recent condition assessment reports by BECA confirm that our hospital is either the worst or one of the worst in NZ and in all categories we are either poor or very poor. We are working closely with the Ministry of Health and a Northern Advisory Group which will provide independent advice on what the priorities are for the region. It is also clear that we have major capacity challenges and we have submitted a business case for funding of significant new building as well as building remediation to address the critical capacity and compliance issues during this period. It includes an Acute Assessment Unit, Paediatrics, Special Care Baby Unit, Outpatient and Ward capacity.

Now that the first stage of the Bay of Islands Hospital development has been opened, the next stage will be progressed. This involves an ambulatory care facility, outpatients, an expansion of the renal unit, community health, as well as an integrated family healthcare facility that will bring three general practices together.

1.3 Signature page

Hon. Dr David Clark
Minister of Health

Sally Macauley
Chairman
Northland District Health Board

June McCabe
Chairman
Finance, Risk and Assurance Committee
Northland District Health Board

Dr Nick Chamberlain
Chief Executive
Northland District Health Board

2 Delivering on Priorities

2.1 Improving child wellbeing

These linkages apply to all priorities under 2.1

Government theme: Improving the wellbeing of New Zealanders and their families	
System outcomes	***Government priority outcomes***
We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child

Priority	DHB activity	Milestone	Measure
2.1.1 Immunisation	1 Work in collaboration with PHOs to support administration capacity and dedicated time in GPs, and strengthen precall and recall processes and activities.	Administration support agreed and provided Dec 2019 to identified practices. Agreed dedicated time for precall and recall. Audit of precall and recall in targeted GPs.	# of children vaccinated on time for each milestone. Decreased number of referrals to Outreach Immunisation Service.
	2 Work with the coordinator of Ngā Wānanga o Hine Kōpū to present immunisation information that is meaningful and relevant to Māori whānau. ***EOA***	Key messages agreed, to be completed Dec 2019.	95% of Māori children vaccinated on time at 8 months. Current figure is 82%.
	3 Engage with marketing specialist to develop a communications strategy targeting all whānau with young families, commencing in pregnancy.	Marketing plan developed, to be completed Dec 2019. Key messages agreed.	# of children vaccinated on time for each milestone.
	4 Work with the PHO to examine the current txt-to-remind messaging within GPs, to support and strengthen messaging of key child health messages from GPs.	Key messaging agreed. Bulk messaging system in place Dec 2019.	Audit of txt-to-remind systems in targeted GPs.

Priority	DHB activity	Milestone	Measure
	5 Identify eligible rangatahi who have not returned a consent form. Work with Kaiāwhina for home visits to support whānau with consent or facilitation of vaccination.	Agreed process for identifying non-consent and engagement with Kaiāwhina Dec 2019. Home visit and or engagement with rangatahi commenced Mar 2020.	# non-consent identified. # rangatahi vaccinated in school-based programme. Number of home visits by Kaiāwhina. Number of non-consents consenting post engagement with Kaiāwhina.
	6 Explore on-line options for distribution of consent form to pre-school programme.	Online consent form available Dec 2019.	
	7 Work with the coordinator of Ngā Wānanga o Hine Kōpū to present HVP immunisation information that is meaningful and relevant to Māori whānau.	Key messages agreed Dec 2019.	
2.1.2 School-based health services	1 Expand Gateway Assessment clinics to district areas.	Confirm clinic in Bay of Islands. Clinics available in Whangārei, Bay of Islands and Kaitaia.	90% of clients requiring a Gateway check are able to access a clinic appointment in the area they live in.
	2 Continue to develop the integrated model of care with emphasis on care coordination for children in quintiles 4-5, tamariki Māori with long-term conditions or ASH-specific illness.	PHN Associate CNM attends a fortnightly multi- disciplinary meeting (Paediatric CNM and Paediatric Outreach CNM) to triage children who are able to be followed up by PHNs.	Prevent readmissions for ASH-related conditions such as encopresis, asthma and respiratory conditions, and for all children who are eligible to receive the flu vaccine.
	3 Increase capacity of current Kaiāwhina service toward a directorate-wide approach to service delivery to increase access for Māori to health services. ***EOA***	Model of care developed. Discussions ongoing with other NDHB services re funding options to grow FTE. Offer Kaiāwhina services to other NDHB services such as dental, paediatric.	Kaiāwhina services increase by 2.0 FTE in 2019/20. Currently 8 FTE.
	4 Continue Rheumatic Fever Prevention Coalition made up of NDHB, Iwi providers, PHOs and other stakeholders	Evaluate throat swabbing and treatment programme. Develop prevention plan based on evaluation for 2019/20.	Acute RF cases stay within the Ministry set target (see CW13 in 5 Performance measures.

Priority	DHB activity	Milestone	Measure
	5 Embed as business-as-usual Specialty Youth Nurses in high schools in Northland. These nurses will cover sexual health, mental health, Year 9 HEADS assessment as well as other health issues. ***EOA***	Nurses will be in place at the start of term 1 2019. Schools regard Specialty Youth Nurses as part of the school culture. Model developed using co-design with PHOs and Whangārei Youth Space. Standing orders and processes agreed. Staff recruited by NDHB and Whangārei Youth Space. Discussion will occur with Hokianga Health Trust this year re upskilling their community nurses who visit their area high schools. Upskilling being delivered to staff.	90% of year 9 students in decile 1-4 Northland schools receive a HEADS assessment and appropriate referrals. 85% of Māori year 9 students in decile 1-4 Northland schools receive a HEADS assessment and appropriate referrals. (currently 30%).
	6 Reorient the PHN model of care toward improved access for children aged 5 to 12 to primary care and child health services, especially for children with complex social needs and/or long term conditions. Support for ASH and focus on engagement with primary care by supporting enrolment.	Implementation of mobile IT system to enable efficiency in the field by accessing client information, assessing and providing treatment at point of care such as schools (with appropriate consent).	Improved access for children aged 5 to 12 to primary care and child health services; especially for children with complex social and/or long term conditions.
	7 Provide quantitative reports in Q2 and Q4 on the implementation of school based health services in decile one to four secondary schools, teen parent units and alternative education facilities.	Q1-Q4	
	8 Northland Youth SLAT 8a Provide quarterly narrative reports on the actions of Northland's youth SLAT to improve the health of the Northland population.	Q1-Q4	
	8b Undertake the following actions to improve performance: • *As per 5 above.* These nurses will cover sexual health, mental health, Year 9 HEADS assessment as well as other health issues.	As per 5 above.	
	• Work with Hokianga Health Enterprises Trust to upskill their School Youth Service to provide the same level of service as in other Northland Schools.	July 2020	
2.1.3 Midwifery workforce, hospital and	1 Develop the Māori midwifery workforce.		
	1a Increase the percentage of Māori midwives in the workforce (currently Māori comprise18% of all Northland practising midwives, 8% of employed midwives and 27% are self-employed). 36% of student midwives in the		Increase Māori among the midwifery workforce across all contexts from 18% to 20% by July 2020.

Priority	DHB activity	Milestone	Measure
LMCs	Northland cohort are Māori. ***EOA***		% of Māori midwifery students in Northland.
	1b Develop and progress a Māori mentorship programme for Māori students and graduates in Northland.	Plan for student and graduate Māori midwifery mentorship developed and business case finalised in 2019/20.	
	1c Encourage engagement of Māori midwives in Nga Manukura o Apopo (Māori Leadership training for Nurses and Midwives).		1-2 Māori midwives per year engaged with Nga Manukura o Apopo 2019/20.
	1d Encourage Māori midwives to engage in postgraduate midwifery education.		Number of Māori midwives engaged in postgraduate study (certificates, diplomas, masters) in each of the 2019 and 2020 years.
	1e Ensure representation from Māori midwifery roopu, Te Kaahu Wāhine in all service planning and development processes in Northland and regular meetings of DHB midwifery leadership and Te Kaahu Wāhine – value the Māori midwifery voice.	Regular (bi-monthly) meetings between Te Kaahu Wāhine and Midwifery Leadership set up and continuedthroughout the year.	% of all leadership and service development groups with appropriate Māori representation.
	2 Enable midwives to work to the full breadth of their scope of practice in all contexts. 2a Core midwives undertake full midwifery assessment, diagnosis and treatment or referral for women needing midwifery review. 2b Midwives undertake all midwifery tasks and are supported to gain confidence in all aspects of practice.		% of women referred by community midwives receiving full midwifery review. % of women having perineal suturing by midwives. % of women having IV insertions by midwives. % of neonatal resuscitations being managed by midwives in collaboration with paediatric team when appropriate.
	3 Encourage and support midwives to complete postgraduate studies.	All leadership positions filled with midwives on postgraduate pathways.	% of midwives in leadership positions undertaking postgraduate study. % of midwives in leadership positions with postgraduate qualifications.
	4 Midwifery clinical leadership throughout the region is coordinated, consistent and available 24/7.	Leadership available 24/7.	% of days midwifery clinical leadership is available in Northland.
	5 Support for midwifery students and new graduates in Northland. 5a Develop an options paper giving consideration to student and graduate scholarships for 2020 students and graduates.	Sufficient clinical placements available to meet student requirements.	All Northland students are able to access sufficient clinical placements and preceptorship opportunities in both hospitals and the community. Two classrooms with appropriate AV equipment available at all times for midwifery students in Northland

Priority	DHB activity	Milestone	Measure
			undertaking their programme by distance education through AUT.
	6 CCDM to be fully operational in our Maternity areas. Trendcare guidelines for Maternity being used and followed. Maternity representative on the CCDM council and working groups. Trendcare to be more aligned with Maternity in version 3.6.1.	All milestones are met for CCDM in Maternity. Core dataset being used for quality improvement.	IRR over 90%. Actualisation 100%. Improvements around staff sickness. Trendcare version 3.6.1 to be implemented by June 2020.
	7 Use a systematic process to establish and budget for staffing FTE, staff mix and skill mix to ensure the provision of timely, appropriate and safe services. Encourage recruitment and retention of Māori midwives. ***EOA***	FTE calculations carried out yearly. More Māori midwives employed.	Safer staffing occurs. Capacity and demand matches on all shifts. Increase midwives who are Māori from 10% in June 2019 to 12% by July 2020.
2.1.4 First 1000 days	1a Continue expansion of Nga Wānanga o Hine Kopu (antenatal programme) across the region. 1b Free oral health assessment and dental treatment initiative for Māori pregnant women attending Nga Wānanga o Hine Kopu, Te Whare Ora Tangata and youth training centres. 1c Develop a suite of child health measure outcomes. Establish a directorate-wide approach to improved engagement with whānau Māori in service development. 1d Improve processes and tools toward better management of child health FSAs, follow-ups and reduction of DNAs to outpatient appointments. 1e Improve timeliness of comprehensive health assessment for children coming into care of Oranga Tamariki through development of a new model of care. Pilot in Whangārei with intention to expand across the region.	Establishment of a regular schedule of wānanga into each rohe: Kaitaia Hokianga Kaikohe Kawakawa Whangārei Dargaville.	Increase % of Māori pregnant women who attended antenatal education/ parenting programmes from 48% in 2018 to 53% by June 2020. ***EOA***
	2 Implement a solution that ensures pregnancy care information sharing between LMCs and general practice.	An appropriate IT solution is identified and if in an allied current workstream, is prioritised for implementation. A successful submission of business case if additional funding if needed.	To be determined once solution is identified.
	3 Implement the NCHIP solution and establish the Connection Service Hub. This will include establishment of an intersectoral taskforce for priority children 0-6 years, such as children lost to services/ recurrent DNAs, children with high ED utilisation, ASH readmissions, Oranga Tamariki children. ***EOA***	NCHIP solution is implemented. The Connection Service Hub is established.	This regional programme of work has specific KPIs:

Priority	DHB activity	Milestone	Measure
			2.1.4 first 1000 days measures (embedded In addition improvement in: • increase % of Māori infants fully enrolled with GP at 3/12 from 66% in Q2 2018 to 71% by Q4 2020 • increase % of Māori babies receiving the first core check before 50 days from 69% in Jul-Dec 2018 to 75% by Jan-June 2020. • Increase in tamariki Māori enrolled with the oral health service from 77% in 2017 to 85% in 2020. (Note. NCHIP will provide access reporting about enrolment and attendance with oral health service by 1 year of age as a milestone).
	4 Realign the current child health advisory group to have broader membership, scope and oversight of the child health programme and measures for Te Tai Tokerau. The alliance will be inclusive of primary care and Māori health partners. Alignment with the Northland Intersectoral Forum programme of work in child health will be enhanced. Utilising data available from the intel team, appropriate measures for the population and work programme of Ngā Tātai Ihorangi will be selected with both quantitative and qualitative data, informing our progress toward addressing the equity gap for tamariki Māori. Establish a directorate-wide approach to improved engagement with whānau Māori in service development, ensuring. participation of whānau Māori in all service improvement and development planning and activity.	Child health advisory group with refreshed membership and TOR established (by 1/09/19). Regular meeting schedule is agreed and actioned. Collective development of a Northland strategic plan for child health.(30 Oct 2019). Child health plan finalised, workstreams prioritised utilising prioritisation tools to support decision making, contributory outcome measures are agreed, information regularly collated and reported to Child Health Programme Advisory Group (by 01 Feb 2020). Progress, trends in meeting selected outcomes tracked over time (quarterly reporting commencing Q3 2020). Data analysis informs service improvement and development	Five-year strategic plan for child health developed, prioritised workstreams identified and timeframed. Quarterly reporting of suite of measures via dashboard provides information necessary for reporting progress and refinement of planned actions by the advisory group. % Māori infants fully enrolled with GP at 3/12 increases from 66% (2018 Q2) to 71% (Q4 2020) . ***EOA*** % Māori infants enrolled with WCTOP and completion of all milestone core checks in the first 12 months increases from 56% (Jan- Dec 2018) to 70% (Jan-Dec 2020). ***EOA*** Reduction in the DMFT for tamariki Māori at age 5 years from 5.96 (2017) to 5.46 (2020). ***EOA***

Priority	DHB activity	Milestone	Measure
		prioritisation. With the implementation of NCHIP, ability to quantify % infants, by quintile and ethnicity, enrolled and attended at oral health service by age 1 year.	
	5 Improve processes and tools toward better management of child health FSAs, follow-ups and reduction of DNAs to outpatient appointments. Priority groups are tamariki Māori and children living in quintile 4 and 5 communities.	Action plan implemented. Exceptions reporting to CHPAG.	Improvement in timeframes for FSA and follow-up appointments in priority clinic areas (Kaikohe and Child Health Centre) and for priority groups of children. Improvement in attendance across all OP clinics. Reduction in DNAs for follow-up appointments for priority group children.
	6 Improve timeliness of comprehensive health assessment for children coming into care of Oranga Tamariki through Gateway.	Referral process in place that enables timely child health assessment with the Specialist Nurse, Gateway service. Clear referral process between Oranga Tamariki and Child Health NDHB – audit.	Number of children referred to assessment. Number of nurse assessments completed. Number of children requiring referral to other health services post assessment.

Priority	DHB activity	Milestone	Measure
	7 Continue expansion of Nga Wānanga o Hine Kopu (perinatal kaupapa Māori programme) across the region. Information about importance of maternal nutrition and food groups is presented and discussed. Lactation consultants deliver the content about the importance of breastfeeding and tips and techniques. Hapu mama and whānau are introduced to local breastfeeding support workers where they live. As we expand the scope of wānanga to include infants in the first year of life, each wānanga will include interactive discussion including breastfeeding information and practical support. Safe sleep education also strengthens the message about the importance of breastfeeding for the first year of life and beyond for all women. Continue delivery of He Pihinga Ora, the Kaiāwhina-led nutrition and activities intervention with whānau, whose tamariki have been referred from the B4SC programme and who are in the 98th percentile.	Establishment of a regular schedule of wānanga (antenatal and postnatal) into each rohe: Kaitaia Hokianga Kaikohe Kawakawa Whangārei Dargaville. 10% of whanāu with tamariki referred to He Pihinga Ora and domiciled in the Whangārei area consent to and participate in the intervention.	% Māori infants who are exclusively or fully breastfed at three months increases from 53% (Jul-Dec 2018) to 58% Jan-June 2010) % of tamariki Māori at a healthy weight at age 4 years (91% at B4SC) remains equitable with non-Māori children (92% at B4SC) and the percentage of healthy weight children does not decrease. % of whānau with referred tamariki who consent to participate in the intervention. % of consenting whānau with referred tamariki who complete a programme. # of referred tamariki and whānau who participate in the planned activities. % of whānau who report positive behaviour, knowledge and attitude about healthy weight in the pre- and post-whānau questionnaire.
2.1.5 Family violence and sexual violence	1 Maintain targeted training for staff, particularly ED and maternity.	Regular Violence Intervention Programme/ Child Protection training sessions (as approved by Shine) are offered to all NDHB staff.	80% of ED and Maternity staff attend, or have attended, VIP/CP training by June 2020.
	2 Embed use of the National Child Protection Checklist for all children under the age of 5 years who are admitted to ED, to ensure a higher Identification rate of children at risk of abuse. ***EOA***	Training is held for all ED staff on use of the Paediatric Assessment Tool.	Audit of National Child Protection Checklist use at 90% by June 2020 to achieve equity for vulnerable children (currently 16%).
	3 Maintain the National Child Alert system with multidisciplinary team meetings.	Continue with regular NCA multidisciplinary meetings two weekly.	100% of actions from meetings actioned in a timely manner.
	4 Sexual Assault Abuse Treatment Service SAATS Forensic facilities now at the four Hospital sites in Northland. Staffed in Whangārei and Dargaville. Clinicians able to travel to Kaitaia and Bay of Islands.	Continue to offer SAATS clinics in each of the 4 Northland sites.	90% of clients requiring a MEDSac examination are able to access it in the region they live in.
	5 Police Evidential Suite colocated at the Sexual Health Clinic offering victims a space for EVIs. Victims and witnesses of violent crime have dedicated space away from Police stations, court etc.	Continue availability of co-located Police Evidential Suite.	100% of victims are able to be seen in a dedicated space away from the Police Station.
	6 Investigate continued resourcing for Multi Agency Family Harm table located at Whangārei Police Offices.	Obtain sustainable funding for 1.0 FTE position at the Family Harm table.	NDHB has 1.0 representation at the Family Harm table.

Priority	DHB activity	Milestone	Measure
2.1.6 SUDI	Continue to implement the regional SUDI Action Plan. Key workstreams include: ***EOA***		
	1 Increase stop smoking support.	Continue with 'opt-off' pilot in Kaipara area. Provide stop smoking education to hapu mama and whānau in all hapu wānanga across Northland. Record referral data to stop smoking service as a result of education received through Hapu Wānanga. Improving collaboration of Iwi heath NGO sector in providing education support and training.	10 mama will engage in the opt-off pilot in the Kaipara area. 20 stop smoking education sessions will be provided across Northland for hapu mama/ hapu whānau. A minimum of 15 hapu mama will register with Toke Rau programme as a result of attending hapu wānanga.
	2 Provide safe sleep devices and guidelines.	Increase the number of Safe Sleep Devices across Northland. Aiming for a minimum of 400 SSD purchased during 2019/20.	A minimum of 400 SSD distributed across Northland.
	3 Align SUDI work with other related programmes to improve outcomes for whānau Māori and other priority groups.	Te Wānanga o Hine Kopu will provide a minimum of 20 wānanga across the Northland DHB region. Waikawa weaving wānanga will provide a minimum of 15 wānanga across Northland.	Te Wānanga O Hine Kopu will complete a minimum of 20 wānanga across Northland. 15 Waikawa weaving wānanga will be completed across Northland.
	4 Healthcare and ECE workers are competent to provide safe sleep education/ ensure safe sleep for infants in their care.	Workforce development. Increase access to education for safe sleep practice assessment and distribution to NDHB staff and other services associated with hapu whānau.	There are 170 ECE services for children under two years in Northland. A minimum of 2 safe sleep space distribution education and practice trainings will be completed. Each training will have a maximum of 20 ECEs participating. ECEs will be prioritised; % pēpē Māori enrolled and/or quintile 4/5.
	5 Families and whānau receive education and support. Focus for 2019/20 is to enhance current programme of weaving wānanga and safe sleep space distribution to include: • incorporate the programme of weaving wānanga into Nga Wānanga o Hine Kopu (kaupapa Māori antenatal programme) • online registration for wānanga • online referral for safe sleep spaces and enhanced regional distribution	Refer to actions 2 and 3.	Provide 2 safe sleep education mornings with ECE providers. Engage ECE services in current safe sleep practices.

Priority	DHB activity	Milestone	Measure
	model • expand/enhance programme of SUDI risk assessment and education, referral and safe sleep space distribution to include whānau attending maternal health and addiction services and general practice • expand engagement with ECE centres to ensure safe sleep policies and workforce education with provision of mini-wahakura for Kohanga Reo centres across the region.		

2.2 Improving mental wellbeing

These linkages above apply to all priorities under 2.2

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

Priority	DHB activity	Milestone	Measure
2.2.1 Inquiry into mental health and addiction	All of the actions in section 2.2 are consistent with the findings of the Mental Health Inquiry.		
	1 "Placing people at the centre" by including people with lived experience of mental illness. • expand the consumer leader group (regionally) • use co-design processes across all services.	 Jan 2020 Sep 2020	
	2 Focus on improving whānau engagement.	Sep 2019	
	3 Enhance relationships with the NGO sector: • reconfigure the NGO executive forum	 July 2019	
	• explore collaborative contracting options with MSD	Jan 2020	
	4 Primary care: Procare pilot to be rolled out in 2018/19-2019/20. • support the transition of services to the new primary health entity, Te Kaupapa Mahitahi Hauora – Papa O Te Raki Trust. • support the development of integrated primary health contracts.	 Jan 2020 July 2019	

Priority	DHB activity	Milestone	Measure
	5 *Options for earlier intervention across the primary care spectrum.* NDHB has a primary mental health pilot (Te Tumu Waiora) currently underway. This roll out will continue through to January 2010 and conclude with an evaluation.	Actions 5-16 are in response to the 1 July 2019 guidance update, and relate to the wellbeing budget for which money has not yet been allocated. NDHB is expecting to submit bids as and when requested by MoH and will develop milestones and measures accordingly at this time.	
	6 *Improved options for acute responses.* NDHB is developing an overnight acute support bed in the Far North, supported by the crisis intervention team and the community mental health team.		
	7 *Suicide prevention and postvention*. MH101 Mental Health Literacy Training and Lifekeepers - Suicide Prevention Training is delivered in the community. Fusion is a Postvention response that includes intervention and prevention in Northland. Our Suicide Prevention Lead is currently a member of the Health Quality & Safety Commission's Suicide Mortality Review Committee (SuMRC) and the National Māori Caucus – Ngā Pou Arawhenua.		
	8 *Actions in relation to Equally Well.* Work is currently underway in conjunction with nurse professional lead and clinical director regarding improving physical health outcomes for Northland MHAS clients. This work is in advance of and in preparation for the HQSC national initiative still to be rolled out.		
	9 *Improving access and reducing waiting times*. Work is underway around improving the pathway for non acute adult referrals to secondary mental health services, reducing wait time and improving access.		
	10 *Ongoing commitment on reporting to PRIMHD.* NDHB continues to comply with PRIMHD reporting requirements.		
	11 *Ongoing commitment to transition/ discharge plans and care plans.* Work will continue in this area to improve quality.		
	12 *Supporting Parents, Healthy Children to support early intervention in the life course.* Analysis of stocktake undertaken, will be working with NGO/NDHB Executive Forum to agree on a Northland sector approach to future implementation.		
	13 *Improving co-existing problems responses.* Mid North single point of entry into AoD services collaboration between specialist services, local Māori provider and AoD-focused NGO to increase ease of access.		
	14 *Reducing inequities.* A Cultural Clinical Governance forum has been established and will be linked to MHAS Clinical Governance Group to ensure inequity issues for Māori are appropriately raised, discussed and strategies developed.		
	15 *Improving employment and education and training options for people with low prevalence conditions.* NDHB has employment support services		

Priority	DHB activity	Milestone	Measure
	underway in two Northland communities. Favourable results to date indicate the programmes are performing well.		
	16 *Implementation of models of care for addiction treatment, with particular reference to the Substance Abuse [Compulsory Assessment and Treatment] Act 2017 (SACAT).* Capacity of residential detox service in Kaipara was expanded under Te Ara Oranga. All systems and processes to enable Northland clients to be held under SACAT are in place, however no clients have been treated under SACAT to date.		
2.2.2 Population mental health *MHA services will continue work to roll out the model of care for the sector. Key priority areas are described here.*	*Māori and Pacifica* – culturally enhanced clinical practice:		
	1 MHA services will continue working on the culturally enhanced clinical practice pathway in partnership with the NDHB Māori Directorate. It is envisaged that this action will assist with reducing inequities for Māori accessing MHA services.	Ongoing	% of Northland population accessing NDHB mental health services Baseline data year ending 30 June 2019: • Māori: 5.2% • Non-Māori: 4.3% • Total: 4.6% ***EOA***
	2 Continue work to develop the strategic action plan to deliver enhancement of cultural competency across the MHA workforce.	Ongoing	
	3 Continue work to include completion of cultural training as part of staff KPIs.	Ongoing	
	Outcome measurement approach across all services		
	4 Continue work to ensure an outcome measurement approach is adopted across all services.	Ongoing	
	5 Consolidate NGO data forum. 6 Implement changes to the Results Based Accountability reporting framework.	June 2020	
	Improved integration and collaboration between other health and social services – Procare Primary Mental Health initiative		
	7 Consolidate and extend the Procare primary mental health project, which focuses on increasing community access to brief interventions in primary health settings.	Ongoing	
	8 Review implementation of two practice sites in 2019/20. 9 Review implementation of the NGO Health Coach initiative.	Ongoing	
	10 Explore further funding to extend the Procare PMH project.	Jan 2020	
	Supporting Parents, Healthy Children (SPHC)		
	11 Refresh the terms of reference for the SPHC steering group.	Aug 2019	
	12 Use outcomes of the 2018/19 stocktake to complete a gap analysis.	Sep 2019	

Priority	DHB activity	Milestone	Measure
	13 Develop a sector-wide plan for implementation of SPHC guidelines.	Jan 2020	
	Housing First implementation in Northland.		
	14 Continue supporting implementation of the Housing First initiative in Northland.	Ongoing	
	15 Continue work to relocate mental health services to the integrated community hub in Whangārei city.	Ongoing	
2.2.3 Mental health and addictions improvement activities	1 Continue work to complete the Zero Seclusion Strategy by focusing on ongoing work to develop relevant staff KPIs.	Ongoing	Total number of seclusions events (Māori and non-Māori events). Baseline data year ending 30 June 2019: • all clients: 112 events • Māori: 77 events • non-Māori: 35 events. June 2020 target: • reduce number of seclusions. ***EOA***
	2 HQSC Transitions Strategy has a focus on successful transition of longer term Community MHAS clients back to the primary care setting. Successful transition is defined as clients not returning to the service within 90 days of discharge. The Connecting Care Transitions Project is being coordinated nationally by HQNZ. NDHB has focused its project on Whangārei General Adult Services.	Ongoing	% of Whangārei General Adult Services discharges to primary care returning to service within 90 days of discharge (Māori and non-Māori). Baseline data year ending 30 June 2019: • all clients: 13.8% • Māori: 20.8% • non-Māori: 12.3%. June 2020 target: reduce % of discharges to primary care returning to service within 90 days of discharge. ***EOA***
	3 HQSC projects still to launch in 2019/20 include: • physical health (metabolic monitoring) • adverse events • medication management.	June 2020 Measures to be confirmed by HQSC.	Measures to be confirmed by HQSC.

Priority	DHB activity	Milestone	Measure
2.2.4 Addictions	1 Te Ara Oranga to continue in year 3: • review service provision arrangements • explore options to enhance tikanga based services.	Secure ongoing funding July 2019. Ongoing.	% of Te Ara Oranga referrals resulting in a face-to-face contact. Baseline data year ending 30 June 2019: • Māori: 60.3% • non-Māori: 59.4% • total: 59.9%. • June 2020 Target: 62.0%. ***EOA***
	2 Consolidate the regional integrated MHA DHB/ NGO Addictions Forum.	Quarterly meetings – ongoing.	
	3 Develop a joint workplan for the addictions sector. Areas for possible inclusion: • review of wait time data • identify alternative data collection • review of addiction treatment pathways • review of triage processes for addiction services.	Develop measures for ongoing monitoring and review by Oct 2020.	
2.2.5 Maternal mental health services	1 Consolidate the Primary Mental Health Maternal Mental Health forum.	Ongoing quarterly forum.	Measure – % of Northland female population aged 15-45 accessing NDHB maternal mental health services Baseline data year ending 30 June 2019: • Māori: 1.0% • non-Māori: 1.4% • total: 1.2%. June 2020 Target: 1.4%. ***EOA***
	2 Utilise the stocktake of community based maternal mental health services and the reporting developed in 2018/19 to reduce health inequities for pregnant women and women with children up to 36 months old. • use of monitoring systems to complete a gap analysis • to identify priority populations for service delivery and increase access to services.	Develop a joint workplan across services by Jan 2020.	
	1 Maternal Mental Health will co-locate a team member a day a week to 3 sites where maternity clinics see high percentages of Māori women. The MMH clinician will actively promote and triage referrals from LMCs for Māori women.	Oct 2019.	
	2 Hokianga Maternity Services will be allocated an additional day per week where a MMH clinician will be co-located.	Mar 2020.	
	3 Kaupapa antenatal wellbeing program is actively promoted by the MMH clinicians.	Jan 2020	
	4 MMH team will closely monitor uptake of referrals of Māori women and provide assertive follow up and contact to increase take up of service and to retain Māori women in service.	Oct 2019	

2.3 Better population health outcomes supported by a strong and equitable public health and disability system

These linkages apply to all priorities under 2.3

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

Priority	DHB activity	Milestone	Measure
2.3.1 Engagement and obligations as a Treaty partner	1 Te Kahu o Taonui (Iwi Relationship Board) have an agreement with the Northland DHB to work together to reduce the health inequities of Māori in Tai Tokerau (Northland). The Terms of Reference relate to: • focusing on achieving outcomes for whānau that are premised on a whānau-centred approach that recognises and nurtures whānau capability and resilience while delivering effective services so that whānau are able to develop their own appropriate responses to their needs and aspirations • seek to target investment to support whānau health and wellbeing that enable whānau to be self-managing, to be confident about taking responsibility and making decisions to improve their own lives, and capable of accessing the level and quality of services they require • deliver better results for whānau while recognising that some whānau, who deal with complex, multi-generational and multi-layered issues, require a lot more intensive support and assistance.	Funding redistributed to improve whānau-centred approach to service design and delivery. Te Kahu o Taonui meetings held every quarter.	Māori Health Directorate budget has increased funding. Minuted decision-making by Te Kahu O Taonui and Northland DHB to strategy and investment.
	2 Begin a process for Commissioning for Health Outcomes in 2019/20. The community engagement with whānau and Māori health providers (Aug 2018-Apr 2019) has provided the premise for: • a working group of Māori health providers and Iwi technical advisors to oversee the redesign of health services • identification of health priorities for whānau • redesign of health services – models of care/ packages of care designed to meet the health priorities and needs of whānau.	Redesign of existing Māori service models based on community engagement and data and negotiation of future Māori health services.	Decisions of working group are minuted between Māori health providers and the Iwi Technical Advisory Group. Redesigned Māori health services are prepared for 2020 Commissioning for Outcomes.
	3 Build capability and capacity for the Māori workforce across the health sector by employing a Workforce Equity Manager to work closely with hiring managers to provide advice and guidance in recruitment and selection processes to increase Māori workforce growth. *[This action aligns with*	Workforce Equity Manager employed by Aug 2019.	Increase the percentage of new Māori employees across the workforce from 16.5% to 18.5% (which will increase the number from 517 to 590). *[Same*

Priority	DHB activity	Milestone	Measure
	2.3.12a Workforce priorities.] ***EOA***		*measure as in action 3 in 2.3.12a.]*

Priority	DHB activity	Milestone	Measure
	Three of the Northern Region DHBs (Auckland, Waitemata, Northland) are in the process of signing off terms of reference that embody a strategic relationship with Iwi and DHB Chairs/CEs to influence planning, performance accountability and strategy. ***EOA***	Workplan developed and agreed to. Regular report to the Board on equity outcomes across the three regions. Services that are funded/ provided will have a focus on achieving health equity. Review of funding streams and identifying realignment of funding. Workplan agreed to. Dashboard developed and reported on quarterly. Mahitahi Hauora, NGO sector services monitored.	Māori Health Services review completed. Equity framework developed.
2.3.2 Delivery of Whānau Ora	Strategic change to support Whānau Ora.		
	DHB owned services		
	DHB Takawaenga Services (Māori inpatient care) • Introduce a new model of care that supports whānau decision-making • Implement a set of Practice Standards for the service to show the professional standards expected of Takawaenga in working with Whānau and Northland DHB's medical/ surgical services.	Introduce tablets to the service to record patient notes and upload to main server. Implement and review standards. Review of standards conducted by June 2020 and updated.	Test sites are identified and data collected and analysed for performance by June 2020.
	Māori Health Community Services Review		
	1 Implement the review of Māori health services to begin the process of incorporating whānau feedback (from the community engagement hui over the last 8 months) to guide the establishment of a Commissioning for Outcomes Framework.	Business case developed and presented to Board for sign off.	Māori health services: • are fit for purpose • align with whānau priorities • contribute to eliminating inequities and improving outcomes for whānau • improve workforce opportunities.
	2 Align service design and delivery of Māori health services to the Whānau Ora Commissioning Agency – Te Pou Matakana, procured services.	Commissioning for Outcomes Framework completed in readiness for procuring services.	
	3 Design Rongoa Māori services with key rongoa practitioners in Te Tai Tokerau as part of the Commissioning for Outcomes framework.	Rongoa Māori services designed and agreed to.	
	4 Align Māori health locality planning as an outcome of the Māori health services review with the newly developed primary health entity Mahitahi Hauora.	Locality planning initiated.	
2.3.3	1 Continue to ensure that Care Capacity Demand Management is planned, coordinated and appropriate for staff and patients through the CCDM	All areas monitored and will be working towards meeting all the Safe Staffing	Milestones all met by all wards.

Priority	DHB activity	Milestone	Measure
Care Capacity Demand Management	Governance Group by: 1a Maintaining monthly meetings 1b Adhering to the high level CCDM plan which includes a framework for progressing to BAU in Whangārei as well as inclusion of rural hospitals in Kaitaia, Dargaville and Bay of Islands. We are including all wards/areas in CCDM and not just inpatient wards as stipulated by the MECA agreement.	Healthy Unit milestones. Working in partnership with our unions.	All areas working towards BAU.
	2 Carry out all quality audits using the Trendcare Acuity Tool as per Trendcare gold standards	Accurate Trendcare data. Trendcare upgrade to 3.6. HI7 Interface between Webpas and Trendcare implemented.	100% actualisation. 90% Inter-Rater Reliability 10. Upgrade 3.6 and HL7 in place. Patient types within benchmark.
	3 The Core Data Set (CDS) is made up of 23 measures, all of which are required for the CDS to be considered fully implemented. The 23 measures are from the three sides of the CCDM triangle: • quality patient care • quality work environment • best use of health resources	Ability for nurses to take annual leave.	All areas will be using the CDS as part of quality initiatives in their areas. Reduced falls in wards. Reduced sickness for nurses. Less overtime required to be worked by nurses.
	4 Employ all nurses who graduate from Northland Polytech to help reduce inequities in our workforce (we currently have a 34% Māori population but only 14% of nurses are Māori). The pipeline for nursing students at the Polytech recruits Māori, age 25 or under. Staffing methodology. A systematic process is used to establish and budget for staffing FTE, staff mix and skill mix to ensure the provision of timely, appropriate and safe services. This takes places yearly to ensure capacity meets demand. ***EOA***	Safer staffing in all areas.	Increase nursing staff who are Māori from 14% in June 2019 to 16% in June 2020. Recommended roster meets agreed targets for deficit/surplus. Higher number of Māori nurses employed as new grads. Capacity of nurses meets the demand of patient requirements on most shifts. FTE calculations have taken place and safe staffing approved by ELT.
	5 Northland DHB uses a Variance Response Management (VRM) system to support the right staff numbers, mix and skills at all times for effective patient care delivery. We have a real-time HaaG (Hospital at a Glance) screen that is fed by Trendcare and have developed an Integrated Operations Centre (IOC) with its own manager.	IOC fully operational VRM plan in operation in hospital and in all areas of the hospital.	Validated acuity data is used at all daily ops meetings to forecast current and future shifts up to 24 hours in advance.
2.3.4 Disability	1 Continue to increase the annual percentage of successful completion rates for the Disability Responsiveness e-learning course revised 2018/19 including:	Q4 reporting. Baseline rates for 2018-19 TBC.	Completion rate for new staff 80%. Completion rate for existing staff 80%.

Priority	DHB activity	Milestone	Measure
	• including it in the orientation programme for all new staff • planned activity to increase the completion rates for existing staff and those requiring a two yearly update • revision of course coding and data collection process for quarterly/annual performance reporting.		
	2 Initiate a programme of work for identifying and reviewing where improvement can be made to organisational policies and procedures for the collection and management of patient information for those with impairment/ disabilities. ***EOA***	Focused programme of work initiated Q2, with consumer engagement in the review process.	Number of prioritised policies, procedures and reviews completed with consumer input. Baseline Q1 TBC.
	3 Continue to increase the number of services actively promoting and providing Health Passports (a consumer-led communication option for those with disabilities or impairment): This will enable Social Worker and Takawaenga service-based champions to enhance their support for those with disabilities.	Q1-Q4	Number of ward based champions. Number of service contacts.
2.3.5 Planned Care	**Part one: Current performance actions** NDHB has submitted a comprehensive planned care recovery plan to the Ministry which specifies key actions and timelines regarding the improvement of more timely access to planned care in Northland. NDHB will comply with all requirements stipulated regarding the improvement of Planned Care services. The plan includes:		
	1 Maximise capacity by: • introducing after-hours operating lists (subject to recruitment and union agreement) • increasing use of Kaitaia Hospital's theatre facilities • developing a more predictable flow of outsourced procedures.		
	2 Expand Kaitaia's capacity by acquiring additional resources funded by uplifting Planned Care Initiative funding. Outsourcing of procedures is already occurring but a more stable supply across each year will improve workflow efficiency.		
	3 Establish two new theatres at Whangārei Hospital. These are a critical part of the plan, but the time it will take to establish them requires short term tactics such as outsourcing. We will also expand inpatient bed capacity at Whangārei Hospital and transfer more patients to our rural hospitals to support the additional theatre throughput.	Early 2021	
	4 Inequities are experienced by those located rurally and living in poverty. The delivery of more surgical procedures from Kaitaia will assist in bringing a wider diversity of procedures and specialist access to the Far North. Identifying and progressing potential minor operation procedures which can		

Priority	DHB activity	Milestone	Measure
	be provided from regionally located hospitals within Northland will improve rural access and the cost of travel to a central location.		
	5a Expand orthopaedic and urology procedure lists, and re-establish gynaecology and ENT lists (general surgical already established to a maximum scope of suitable procedures). Expected timeframe for assessment of the sustainability of orthopaedic expanded lists is 12 months post establishment in November 2019 and urology expanded procedure lists at 6 months March 2020 and 12 months September 2020.	Expected timeframes for assessment of the sustainability of expanded lists: orthopaedics Nov 2020 urology Mar 2020, Sep 2020 Reestablish specialty lists: Gynaecology Oct 2019 ENT Mar 2020	
	5b Review and measure staffing models and increase in elective operating volume/ case weight delivery from hospitals located in the region (other than Whangārei) .	Nov 2020	

Priority	DHB activity	Milestone	Measure
	Part two: Three year plan In 2019/20 NDHB will plan, design and start implementation of a three year plan to improve Planned Care Services. The plan will describe actions that demonstrate how NDHB will address the five Planned Care Priorities: • gain an improved understanding of local health needs, with a specific focus on addressing unmet need, consumers' health preferences, and inequities that can be changed • balance national consistency and the local context • support consumers to navigate their health journeys • optimise sector capacity and capability • ensure the Planned Care Systems and supports are designed to be fit for the future. NDHB will engage with the DHB's Consumer Council and other key stakeholders in the development of the plan. NDHB will identify who in our population is experiencing inequities and provide strategies to address these inequities.		
	6 NDHB will provide an outline of our engagement, analysis and development activities for developing the Three Year Plan.	In Q2 a plan is submitted that outlines the proposed approach to develop the Three Year Plan.	
	7 NDHB will undertake analysis of changes that can be made to our Planned Care Services including consultation with DHB Consumer Councils and other key stakeholders.	In Q2 a summary report outlining the outcomes of the analysis and consultation processes to understand local health needs, priorities and preferences.	
	8 NDHB will submit a Three Year Plan to improve Planned Care Services.	In Q3 submission of the Three Year Plan to improve Planned Care Services.	
	9 NDHB will provide the first update on actions taken to improved Planned Care.	In Q4 an update is provided on actions outlined in the Three Year Plan to improve Planned Care Services.	
2.3.6 **Acute demand**	*1 Capturing acute data* NDHB will be early adopters of SNOMED coding, and are working with MoH around the ED subset. Preparation has commenced for the database tables to be swapped out for SNOMED. Orientation training for the ED workforce will occur two weeks prior to implementation.	Q2 programme of work completed, SNOMED coding implemented. Provide a maintenance function within ED software, if a change to the SNOMED codes is required by MOH. ED staff orientation and training completed.	

Priority	DHB activity	Milestone	Measure
		Q3 Evaluate progress.	
	2 Patient Flow Whole-of-organisation integrated operations centre established and resourced, with visibility of timely data that supports decision-making.	Coordination Centre operational Q2	Reduction in ED LOS for all patient specialties. Decrease in code reds.
	3 Mental health patients **EOA** 3a Gather appropriate data to inform the action plan: • average LOS for mental health patients compared to other ED patients • categorise referral source.	July 2019	
	3b Establish a project team to: • analyse data to identify reasons for variance • investigate appropriate changes to the mental health patient pathway to improve average LOS in ED • establish agreed timeframes for change implementation and review.	Sep 2019	
	4. Māori Health Patients **EOA** Identify factors that contribute to a shorter length of stay for Māori presenting to ED.	Q3 Initial Audit completed	
	4 Gerontology GNS placement in ED [see 2.3.8 Healthy ageing].	Q2 GNS appointed. Screening and Comprehensive Gerontology Assessments commenced.	Decreased LOS in ED for those >80 years or younger for vulnerable patients/ groups.
2.3.7 Rural health	Northland has a predominantly rural population; two-thirds live outside the Whangārei urban area, many in isolated locations along difficult country roads. Northland DHB is always cognisant of the needs of isolated populations in the planning, delivery and monitoring of our services, and in setting up, negotiating and monitoring contracts with NGOs. Rural health needs are addressed in many actions in other parts of the Annual Plan. There are also initiatives that aren't reflected in the MoH-driven priorities that form the basis of the plan.		
	Northland's rural and isolated populations form an inherent part of all our planning. Actions throughout the plan consider rurality, even if it is not explicitly stated. The needs of rural populations are specifically addressed in: 2.3.1 Engagement and obligations as a Treaty partner actions 1, 2. 2.3.12a Workforce priorities action 3c. 2.3.13 Data and digital action 4. 2.2.1 Inquiry into mental health and addiction As has been the case in all		

Priority	DHB activity	Milestone	Measure
	MHAS planning and service provision, the particular needs of the Northland population, such as equity and rurality / isolation, will form an inherent part of responding to the inquiry's findings. 2.1.2 School-based health services actions 1, 5 and 6. 2.5.1 Primary health care integration all actions. 2.5.2 Pharmacy action 1. 2.5.4 Diabetes and other long-term conditions all actions.		
	Activities and initiatives that don't fit under MoH priorities:		
	1 Establish a joint working group of Ngāti Hine and NDHB to commence design and planning for phase 2 of Bay of Islands Hospital development, the integrated primary care and outpatient facility.	Q1	
	2 Explore opportunities to expand surgical service provision at Kaitaia for patients in the Mid North and Far North.	Q1	
	3 Explore options for an endoscopist to undertake scope work closer to home for Mid and Far North patients.	Q1	
	4 As part of the comprehensive Population Health Indicators Framework being developed by the Public Health Unit: • define 'rural and urban' from a population health perspective • define 'remoteness' • identify key health issues that are of significance for rural and remote communities • identify disparities between rural and urban population health outcomes.		
	5 Negotiate a workplan with Te Hiku Development Trust for the next 12 months, now that Northland DHB and the Ministry of Health have signed the Te Hiku Social Accord.	Workplan negotiated and agreed to by Q2. DHB works with Te Hiku Development Trust to establish a working group, including reaching agreement on the level of data required to support the relationship.	

Priority	DHB activity	Milestone	Measure
	Telehealth:		
	6 Introduce cardiology valve and colorectal surveillance telehealth consults to patients in the home which will decant work from Whangārei and improve efficiency of the Outpatient Department.	Q1	
	7 Establish general medicine, anaesthetic telehealth outpatient clinics to Kaitaia Hospital to improve the efficiency of the Outpatient department.	Q2	
	8 Dental telehealth clinics to Northland clinics and mobile vans will mean patients will be seen closer to home as well as sooner in some cases.	Q2	
	9 Extend primary care multidisciplinary meetings to the Mid North, focusing on patient case review format achieving a more cohesive shared care approach to managing complex patients.	Q2	
	10 Upgrade of Kaitaia and Dargaville District Hospital ED telehealth network to enable a fully integrated acute care telehealth network.	Q1	
	11 Introduce a diabetic patient reporting app to facilitate monitoring and better control of diabetes, which will lead to better outcomes for patients with diabetes.	Q3	
	12 Northland DHB will enter into a new single PHOSA with Mahitahi Hauora. The DHB's Alliance will be reformed under the new single contracting entity from 1 July, including examining the scope of each forum and the Alliance, including the Rural SLAT. Mahitahi Hauora is in affect a living contracting entity of the concepts of Alliancing. The previous ALT, Te Roopu Kai Hapai Oranga has disbanded with transition of the group to Mahitahi Hauora. This is a significant and fundamental change in how Northland DHB will plan and fund services.	Q3: Rural Health Network will be established with a view to strengthening rural service provision. Terms of reference and membership will be agreed.	
2.3.8 Healthy ageing	1a Continue to increase GP and primary health care team(s) utilisation of Northland's osteoporosis and falls prevention pathways.		Increase in number of primary care sourced referrals/ ethnicity. Total annual ACC/NDHB Partnering Agreement target for high risk falls prevention programme is 232.
	1b Engage with primary care to increase the number of unique NHI referrals to the high risk falls prevention programme for those with frailty who can derive benefit.		Reduction in referrals for those not able to derive benefit from the in-home falls prevention service due to level of frailty (24%) or well enough to attend community based strength and balance classes (10%). Baseline for primary-care sourced referrals currently 26%.

Priority	DHB activity	Milestone	Measure
	1b Increase GP prescribing and uptake of bone protection medication following discharge including: • patient discharge letter to GPs/ feedback promoting exercise and bone protection medication • primary health care team education • Fracture Liaison Service decision support.		Increase in the number of prescriptions for bone protection medication by GP to appropriate fracture liaison patients. Current post discharge baseline 45%.
	2a MoH is developing the national framework for Home and Community Support Services. Part of the national framework, will include the development of a nationally consistent service specification for Home and Community Support Services. This will become the nationally mandated service specification required of DHBs, to be implemented over the next three years.	Publication of a nationally consistent service specification, led nationally. Northland DHB involvement in national and regional consultation processes.	
	2b Planned implementation of the mandatory national framework within three years for all of NDHB's contracted home and community support services (HCSS).	Implementation of national HCSS service specification within three years. Implementation plan TBC.	
	2c Complete a Summative Evaluation of the Mycare Proof of Concept Project including MoH engagement. ***EOA***	Evaluation completed in Q2. Service definition for self-directed in home support established and context within the national framework for HCSS. Acceptability and equity of access including uptake by Māori whānau and networks.	
	3 Address the drivers of acute demand for people over 80 years, including: • screening for fragility and comprehensive gerontology assessment in ED.	GNS appointed and located in ED team [see also 2.3.6 Acute demand].	Reduced time in ED. LOS in ED. % acute admission rates from ED.
	• dedicated ARC practice development RN support focused on continuing to reduce ED presentations for those over 75 years or younger where benefit derived		Reduction in ED presentations from ARC. Rate of ED presentations from ARC. % total ED admissions. #/% ARC admits to ED/1000 ARC bed days.
	4 Continue to augment population health strategies that reduce harm and functional decline: • earlier support and diagnosis of cognitive impairment in primary care	Integrated population health pathways for older people.	SS04.
	• timely access to community stroke rehabilitation including younger Māori ***EOA***	Stroke community rehabilitation target met by ethnicity and age.	SS13 FA5. Baseline Q1 TBC.

Priority	DHB activity	Milestone	Measure
	• reduction in community-acquired pressure injuries in partnership with ACC	Community-focused pressure injury reduction.	Rate of grade 3 and above pressure injuries to hospital.
	• CVD prevention project (renal)	Project milestones met.	TBC.
	• falls prevention (refer 1 above)		SS04.
	5 Provide Northland information for the regional stocktake dementia services and related activity, using the nationally agreed stocktake template.	Northland stocktake completed within Regional HOP Programme timeline.	SS02 actions. Measure met Q2.
	6 Using the stocktake, participate in the Northern Regional prioritisation process for identifying and implementing regional and Northland DHB priorities for implementing the New Zealand Framework for Dementia Care.	Prioritised Implementation Plan(s) completed. Progress reports submitted to MoH Q3 and Q4. Agreed actions under the NRHP completed.	Priorities align with government priorities and system outcomes.
2.3.9 Improving quality	Quality improvement takes many forms and is inherent in the planning and provision of all services. It is a core component of Northland's planning for System Level Measures – see Appendix: System Level Measures Improvement Plan 2019/20.		
2.3.9a Improving quality	Continue to engage with HQSC in the national discussion on reducing opioid harm, especially to obtain granular localised data on gaps as a driver for improvement. The National Inpatient survey had a 16% response rate in Q2 (Oct-Dec 18). The lowest scoring domain remains the communication domain. Specifically, the question addressing medication side-effect information at discharge scores consistently low, with 20% of patients indicating no information on medication side effects was given on discharge in Q2. Of the total respondents, 62% of Māori reported 'yes' to complete information given, compared to 37% for NZ European. Northland has been identified in the Health Atlas as being an outlier for prescribing of opioids. Both the PHO and DHB recently attended the 'reducing opioid harm' HQSC workshop to look at a system-wide approach to reducing harm from opioid prescribing. Granular understanding of systemic gaps is poorly understood and both DHB and PHO participants emphasised the need for localised data from the Atlas to drive improvement. Northland continues to be engaged in this national discussion as an area to improve patient understanding of opioid use, risk and education on pain management at discharge.	Milestones will be developed in conjunction with HQSC as part of this project.	5% increase of patients indicating understanding of medication side effects on the national inpatient survey.
	Patients diagnosed with diabetes often require access to healthcare frequently. Northland's health needs assessment identifies that a higher percentage of Northlanders live with diabetes in comparison to the New	Implementation of diabetic appropriate.	10% decrease in admission for patients with hypoglycaemia.

Priority	DHB activity		Milestone	Measure
	Zealand average. The prevalence of diabetes in Māori is 1.5% higher than European. This in conjunction with patients identifying as Māori are 50% more likely to experience difficulties in accessing healthcare.			
	Introduce a diabetic patient reporting app to facilitate monitoring and better control of diabetes will lead to better outcomes for patients with diabetes. ***EOA***		Provision of smartphone for those with need.	For Māori with diabetes, decrease the equity gap in medical-surgical bed days by one-tenth from 25.9% to 23.3%.
2.3.9b Antimicrobial resistance	Health of older people	1 Reference: NZ Antimicrobial Resistance Action Plan – Objective 3: Infection Prevention & Control. To meet their certification requirements, Aged Residential Care (ARC) providers must comply with the Health and Disability Infection Prevention and Control Standards, including antimicrobial usage.	Q1-Q4.	100% compliance rate against NAS8134:2008 Health and Disability Services (Infection Prevention and Control) Standards (as measured via the Certification audits carried out by DAAs).
		2 Northland DHB will continue in its activities to support ARC services to carry out effective infection prevention and control practices. This includes: • continuation of positive and open communication between ARC services and NDHB staff including: Infection Prevention & Control Clinical Nurse Specialists, ARC HOP Liaison & Practice Development Nursing Team and GP Liaison.	All ARC providers comply with the H&D Standard in Infection Prevention and Control. All ARC providers know how to seek support from NDHB Infection Prevention & Control Clinical Nurse Specialist. (Annual Survey).	Results of survey carried out of Northland DHB contracted ARRC services. Survey issued 1 October 2019. Results analysed and disseminated 30 Nov 2019.
		• on request from ARC providers, NDHB Infection Control Nurse Specialists provide education sessions to ARC HCAs and RNs and advice on systems and surveillance.	CNS assigned case load coverage of ARC facilities. Education and advice provided to HCAs and RNs on request.	Number of sessions delivered by NDHB IC Nurse Specialists in 2019-20.
		• NDHB GP Liaison and Clinicians provide information and advice to ARC GPs and RNs on the best practice management of specific residents with MRSA, and prevention of the risk of cross-contamination.	Feedback from ARC providers (survey).	Nil cross-contamination occurs within ARC facilities.
		3 Encourage ARC staff to have policies and processes in place that support the vaccination of staff and residents and against influenza.	Communications with ARC facilities included in NDHB's annual influenza vaccination campaign. Key vaccination messages communicated with ARC services.	ARRC staff and residents influenza immunisation rates (survey).
	In hospital	4 Continue the recently convened Antimicrobial Stewardship Committee to: • formalise surveillance • provide antimicrobial stewardship advice • discuss the approaches recommended in MoH's NZ Antimicrobial Resistance Action Plan 2017 and consider their application to Northland.	Ongoing	Quarterly meetings of the committee Review of Resistance Plan Application by Dec 2019.

Priority	DHB activity		Milestone	Measure
		5 Continue to produce antibiograms to monitor the rate of change of antibiotic resistance within the DHB.	Ongoing	Annual production and review of hospital antibiograms.
	Primary care	6 (objective 1, priority 1 of the NZ Antimicrobial Resistance Action Plan): Improve awareness and understanding of antimicrobial resistance through effective communication, education and training.		
		6a Strengthen consumer awareness to improve understanding of antimicrobial resistance and the importance of using antibiotics appropriately by holding education awareness events.	Implementation of antibiotic awareness in relevant primary health care education sessions.	
		6b Work with all relevant primary health care clinicians to ensure ongoing education and support to consumers.		
		6c Expand promotion of World Antibiotic Awareness Week.	Communication and promotion of Antibiotic Awareness Week. Appropriate promotion material and support made available via PHO website.	
		7 (objective 1, priority 2): Strengthen communication and education initiatives on antimicrobial resistance and stewardship for all prescribers and those working in primary health care services.		
		Ensure all prescribers, pharmacy, health care team members have ready access to antimicrobial stewardship resources and prescribing guidance	Appropriate resources and prescribing guidance made available to prescribers and relevant health care team members.	100% availability of appropriate resources and prescribing guidance.
		8 (objective 3, priority 9): Infection prevention and control.		
		Maintain all Primary Health Care strategies to encourage immunisation to prevent infection; continue work to increase immunisation coverage equitably across Northland population.	Strategies in place to provide immunisation coverage equitably across Northland population.	2.1.1 Immunisation
2.3.10 Cancer services	Ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (eg, systems/service improvements to minimise breeches of the 62-day FCT target for patient or clinical consideration reasons):			62-day Faster Cancer Treatment target. Monitor quarterly reports to ensure improvements can be made to meet acceptable targets. Review/screen referrals – Māori/PI are prioritised as complex. NDHB FCT reporting captures all new and current patients. Stocktake of existing resources and gap analysis. Analysis of the patients that did not meet
	1 Use regional and local performance data and recommendations to streamline tumour stream pathways, particularly where inequity exists.		June 2019	
	2 Prospective identification, monitoring and intervention throughout the pathway by the CNS Māori/ PI Navigator.		Ongoing	
	3 Tumour Stream CNSs network with iwi providers and psychological support throughout Northland, identifying high risk Māori/PI DNA and barriers (health statistics, institutional racism and complex referrals etc).		Ongoing	
	4 Targeted development of patient and staff resources including education. Developing patient information booklet for Māori (health literacy) on cancer		September 2019	

Priority	DHB activity	Milestone	Measure
	diagnosis and treatment		the FCT targets.
	5 Continued regional collaboration (formal and informal) and reporting to ensure cross-DHB pathways are timely and efficient, including: • Regional Faster Cancer Treatment (FCT) Group • Regional Oncology Operations Group • Regional Cancer Steering Group • regular discussions with Cancer Society.	Ongoing	
	Provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer:		
	6 End of treatment meeting or clinic: Referral to Cancer Society for ongoing care (survivorship). Medical oversight in terms of surveillance.	Ongoing	
	7a Develop follow-up care plans for both secondary and primary health. 7b Commence documentation on PMS (Concerto) to ensure visibility to other services outside Cancer & Blood Services.	June 2019	
	8a Referrals to appropriate service providers for self care such as nutrition, physical therapy and psychological support. 8b Implement 'Mindfulness' sessions within Cancer and Blood Services. Continue referrals to our Psychological/ Support Care staff as per usual.	Ongoing	
	9 Work with the Ministry of Health to develop a Cancer Plan and implement the local actions from within it.	As defined by the Cancer Plan.	
2.3.11 Bowel screening	These actions address requirements in the lead-up to the implementation of the National Bowel Screening Programme (NBSP), likely to occur in 2021.		
	1 Complete NBSP information document.	Send to MoH by Oct 2019	
	2 Identify roles and staff requirements for the introduction of NBSP.	Oct 2019	
	3 Develop and finalise budget for NBSP.	Dec 2019	
	4 Set up governance and steering group structure for NBSP.	Oct 2019	
	5 Recruit staff required pre implementation – staged as appropriate.	3-12 months prior to commencement of NBSP	
	6 Continue collaboration with the Northern Region BSP network.	Ongoing	

Priority	DHB activity	Milestone	Measure
	7 Continue to secure additional activity by outsourcing to private and locum endoscopists (as has already occurred during most of 2018/19). P1 Urgent and Surveillance colonoscopies have consistently been meeting target wait times. P2 wait times have been reducing each month, and we have an expectation of meeting the P2 target by Sep/Oct 2019.	Outsourcing to continue occurring.	P1 and P2 waiting times.
	8 Develop a Business Case for the recruitment of an additional full time permanent Gastroenterologist for 2019/20 in order to sustain this increased activity and maintain wait time targets prior to NBSP commencing.	Business case developed. Gastroenterologist appointed.	
2.3.12 Workforce			
2.3.12a Workforce priorities	1 Foster a safe, well, engaged, enabled workforce supported by effective leadership.		
	1a Equip leaders and teams with the ability to identify and respond appropriately to disengaged and/or unwell staff.	Implementation of the Mayo Clinic Wellbeing Index.	Survey of staff via the index will provide a baseline for future measurements.
	1b Develop wellbeing support pathways.	Support pathway tool for all staff designed and developed.	Increased access to EAP. Number of downloads of a web app and/or webpage hits. Regular feedback forum access.
	1c Create and build further opportunities for participation at various wellbeing initiatives.	Further opportunities created for participation in physical fitness and resilience programmes. Further awareness and uptake of existing wellbeing initiatives built.	Number of staff participating on programmes.
	1d Develop a reward and recognition framework.	A reward and recognition framework for the organisation designed and developed.	Number of rewards provided with narrative.
	1e Develop a leadership development programme based on the State Services Commission Leadership Success Profile (LSP)to	Development of participants' leadership competencies, based on the State Services Commission LSP. LSP competencies captured into the existing HR information system will be explored, as will connecting to national talent management systems.	10% of our identified/ potential leaders are registered on the programme.
	2 Workplace violence prevention programme.		
	2a Review current Workplace Violence Prevention (WVP) workforce learning opportunities with WVP Programme Manager.	June/July 2019 review completed.	June/July 2019 WVP Workforce Learning Opportunities report completed.

Priority	DHB activity	Milestone	Measure
	2b Develop a comprehensive WVP workforce learning package based on June/ July 2019 Review.	Aug 2019 Learning Opportunities Package developed.	Aug 2019 WVP Learning Opportunities Package Completed.
	2c Integrate the June/July 2019 WVP workforce learning opportunities package into DHB workforce learning platforms.	Aug/Sep 2019 Learning Opportunities Package integration developed.	Aug/Sep 2019 WVP Learning Opportunities Package integration into DHB workforce development platforms completed.
	2d Review / evaluate 2019 WVP workforce learning opportunities package.	Aug 2020 Evaluation of WVP Learning Package.	Sep 2020 evaluation report completed.
	3 Grow the capacity and capability of our Māori workforce. *[See also 2.3.1 Engagement and obligations as a Treaty partner]*	Appointment of the Workforce Equity Manager dvisor as a mechanism towards growing the capability and capacity of the Māori workforce.	Increase the percentage of new Māori employees across the workforce from 16.5% to 18.5% (which will increase the number from 517 to 590). *[Same measure as in action 3 in 2.3.1.]* **EOA**
		Capability and capacity of the non-regulated workforce continues to be built through HWNZ.	More non-regulated health workforce acquiring qualifications.
	3b Continue to develop new and enhanced pipeline options for the recruitment of Māori health professionals – 'Grow our own'.	Continued implementation of Kia ora Hauora. Nga manukura o apopo – foundation leadership for nursing. Kurawaka – Advanced Leadership for nursing. Prioritise pipeline options for Māori workforce into Allied Workforce. Prioritise Māori applicants into the NETP/NESP programme. Provide cultural support for Māori New Graduates into their second year.	Increase of graduates into the workplace. Increase in number of Māori nurses into the workplace. Increase number of Māori employed into Allied Health positions.
	3c Recruit more Māori (and Pacific) into the workforce.	Each GM has set agreed workforce targets within their Hoshins. Recruitment of an Workforce Equity Manager (see 3). Implement a positive discrimination (affirmative action) policy.	Increase the number of Māori across the workforce. Increase Māori in the nursing workforce from 14.3% to 16.3%. **EOA** Increase Māori in the midwifery workforce from 10.1% to 12.1%. **EOA**
	3d Strengthen the cultural competency across the workforce.	Ensuring recruitment and selection processes include an equity lens.	Integrate an equity lens on two organisational training courses (Strategic

Priority	DHB activity	Milestone	Measure
		Equity lens identified for two organisational development courses (Strategic Leadership and Communication). Te Kaupapa Whakaruruhau (Cultural Quality Programme) continues to be provided to all staff, including supporting the internal facilitation development of 'Engaging with Māori'. A Kaupapa Māori audit tool implemented across the organisation. Māori health KPIs for Executive Leadership Team including cultural competency.	Leadership and Communication). Retention of the Māori workforce. Increased cultural competency across the organisation. Decrease in number of complaints from patients. ELT Māori health KPIs are reported on.
	3e Prioritise funding to support nurse prescribing and nurse practitioner pathways for Māori.		Increase Māori nurse practitioners in the DHB workforce from 17 to 19. ***EOA***
	4a Attract, recruit and develop a talented workforce.	Investment in workforce to recognise equity, relativity and complexity.	Māori equity lens applied to all job description scoping exercise.
	4b Implement an Employment Values Proposition framework.	Northland DHB employment brand built in partnership with Adcorp that aligns with the vision, values and behaviours of our organisation.	Decrease in staff turnover. Increase in number of applications received.
	4c Focus recruitment and retention strategies on: • rural hospital • mental health • allied health.	Participation on the national programme; dates to be determined. Pipeline options for Māori workforce in to allied workforce to be prioritised.	Increase in recruitment and retention at Kaitaia, Bay of Islands and Dargaville hospitals. Increase in recruitment and retention of mental health workforce.
	4d Initiate nurse practitioners' professional development as part of the Māori Workforce Affirmative Action plan that seeks to identify where current Māori work who are in leadership positions, how we can retain and continue to develop. The professional development of nurse practitioners will be raised at the Nurse Practitioners Forum and at national meetings of Directors of Nursing and mIdwifery.	Continued availability of training programmes based on current learning pathways 'Living our Values', 'Management & Leadership', 'Driving Excellence' and 'Enabling Wellbeing'. Access provided for both face-to-face and online participation to our primary care partners.	Ensure optimum participation at training is met along with post course requirements to embed learnings.
	NDHB will work to align with the other Northern DHBs to secure $4k pro rata for Professional Development for Nurse Practitioners.	March 2020.	

Priority	DHB activity	Milestone	Measure
	4e Provide scholarship opportunities.	Continued implementation of the unregulated workforce fund. Investment in workforce to recognise equity, relativity and complexity of whānau health outcomes.	Increased number of staff with tertiary qualifications. Annual budget recognises scholarships and disbursements to Māori and non-Māori in tertiary study.
	5 Reshape the workforce to deliver innovative and integrated models of care in response to changing population needs by continuing to implement the Telehealth service across the rural mid and far north – see 2.5.1 Primary health care integration action 6.		
	5a Implement the Calderdale Framework – see 2.5.1 Primary health care integration action 6.		
2.3.12b Workforce diversity	1 Increase opportunities for Māori candidates (recruitment role).		
	2 Improve accuracy and completeness of HWIP data, specifically around unknown ethnicity. ***EOA***	Reduced % of unknown ethnicities.	Decrease the number of unknown ethnicities by 50% from 226 to 113.
	3 increase visibility of Māori participation in workforce through new dashboard.		

Priority	DHB activity	Milestone	Measure
2.3.12c Health literacy	Discuss this draft model for health literacy at ELT during Q1 2019/20 and develop an action plan across the organisation. 	Q1	
	In HOP services, develop innovative education and training, and 'easy to reach' health literacy resources for primary care, NGO/ARC workforce.	Education and training resources established.	
2.3.13 Data and digital	1 Regional Community and Collaborative Care project. Replacement of Jade mental health and community care health information system – key enabler of improving equity and enabling integrated consumer-centred care. (Milestones subject to ongoing planning.)	Build-test-deployment activities underway with preferred vendor. Q2 completion of the design phase with preferred vendor. Q3-Q4 commencement of the build-test-deploy phase with preferred vendor. Approved design including completion of Technical Quality Assurance.	Completion of RFP activities. Detailed design with build/ test/ deployment plan developed. Approved Technical Quality Assurance. 50% of build phase completed.
	2 Migration of Northland onto regional instance and operate model for the clinical portal.	Data Integration to WebPas 30 Aug 2019.	Data migration and messaging activated. NDHB user acceptance certificate.

Priority	DHB activity	Milestone	Measure
		User acceptance testing 20 May 2020. User training completed 15 June 2020. NDHB go-live 01 June 2020. User on-boarding 15 July 2020.	Majority of users complete formal training. All NDHB functionality deployed to production. Concerto 6 disabled.
	3 NCHIP. Single online view for all practitioners involved in the 29 child health milestones from birth to six years of age.	Refer 2.1.4 First 1000 days.	Refer 2.1.4 First 1000 days.
	4 Telehealth – NDHB Zoom Self Service Portal.	Launched March 2019. Significant increase in Zoom use for both clinical and corporate.	Work towards defining EOA for telehealth during 2019/10.
	5 eMedicine for medical and surgical wings.	System live Q2 2021/22. Removal of paper medical charts and electronic dispensing / alerts.	Most inpatient services in NDHB will be fully electronic with medications management.
	6 eVitals. Will begin requirements analysis and options scanning for making patient observations and assessments available to clinicians when and where they need them.	Q4 2020/21. Defined business objective and selection of solution.	Patient physiological parameters in general wards will be recorded and visible through digital systems.
	7 Inter and Intra electronic referral pathways will be live and deployed. Community (non-GP) referrals will be electronic between providers and the DHB.	Q2 2019/20. Electronic referral pathways will be live across internal DHB services and locations, NDHB to Auckland Metro DHB services and from non-GP practitioners into the DHB.	90% of paper/faxed or emailed referrals will be eliminated from all referral pathways and replaced with standardised electronic referrals.
	8 Electronic sign-off will be operational across the DHB. Electronic ordering will be designed and deployed.	Q4 2019/20: All laboratory and radiology results in the DHB will be electronically signed off with no further paper printing of results. Removal of paper lab orders. Q3 2020/21: Implementation of end-to-end digital requesting, management and sign-off of laboratory and radiology tests	
	9 Implementation of Provation endoscopy information system to support bowel screening programme.	2019/20. System implemented and in operation.	

Priority	DHB activity	Milestone	Measure
	10 Security plans for 2019/ 20 (subject to confirmation of funding) include:		
	10a Identify and establish the cybersecurity "Risk Profile" for all critical assets across the region on a system-by-system basis.	Risk assessments completed Q4. Risks identified and understood with mitigation plans if required.	
	10b Refine the security program foundations and continue to develop Cybersecurity maturity for the region.	Cyber Security Maturity assessment updated Q4.	Average capability maturity score moved from 2 to 3.
	10c Initiate dedicated Security Operations Centre (SOC).	Dedicated SOC established Q4. People, process, technology in place and operating.	
	11 Agreement has been reached on the governance arrangements for the Northern Region ISSP Programme, incorporating a new Regional ISSP Design Authority, and Programme Delivery responsibility.	Forums fully established mid-2019.	One Northern Region delivery plan and associated artefacts.
2.3.14 Collective Improvement Programme	A Collective Improvement Programme will be chosen jointly by the Chief Executives of all DHBs; Northland DHB agrees to participate in a suitable programme.	Collective Improvement Programme chosen.	
2.3.15 Delivery of regional plan priorities	*Dementia care is addressed in action 6 in 2.3.8 Healthy ageing.*		
	1 **Hepatitis C.** Northland DHB's Clinical Nurse Specialist for the Liver Service attends the quarterly Northern Regional Alliance meetings for Hepatitis C via video conference. NDHB's health pathway for Hepatitis C has been modelled on the Auckland pathway. We also deliver education sessions to GPs regarding the new pangenotypic antivirals for Hepatitis C and act as a resource for them. In addition our CNS delivers monthly liver clinics in Bay of Islands Hospital which include Hepatitis C patients.		

2.4 Improving wellbeing through prevention

These linkages apply to all priorities under 2.4

Government themes: Improving the wellbeing of New Zealanders and their families Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a clean, green and carbon-neutral New Zealand)	
System outcomes	***Government priority outcomes***
We have health equity for Māori and other groups	Support healthier, safer and more connected communities

Priority	DHB activity	Milestone	Measure
2.4.1 Cross-sectoral collaboration	1 Participate at the Family Harm Table to provide health input in triaging of cases from intersectoral agencies such as Oranga Tamariki, Police. ***EOA***	Allocation of NDHB staff member to the triage table by 1 July 2019. Funding approved and NDHB staff member appointed.	
	2 Continue membership of the Northland Intersectoral Forum, and continue CEO's role as chair of the Social Wellbeing Governance Group (SWGG). Areas of focus to include youth suicide, family violence, high need children and families. ***EOA***	New SWGG established and new ToR signed off August 2019. SWGG executive group operational. Information Sharing Memorandum completed Dec 2019.	
	3 Participate in NIF Operational Leaders Group Child Friendly Northland initiative which will enact strategies for child and youth wellbeing. ***EOA***	Group constituted. Appointment of senior executive representative from NDHB onto Leadership Group. Implementation of strategies identified by NDHB to contribute to collective interagency strategies for child and youth wellbeing in Northland.	
	4 Continue to participate in ongoing cross-sectoral work for communities in Otangarei. NDHB provides the lead for the healthy lifestyles workgroup. ***EOA***	Group initiates community project for youth. Reconfigure Rākau Rangatira in consultation with Te Hau Awhiowhio to provide employment broker and counsellor as part of the MSD-funded Oranga Mahi. Fitness circuit concept codesigned with	

Priority	DHB activity	Milestone	Measure
		community and implemented as part of Kainga Ora initiative in Otangarei.	
	See also2.3.7 Rural health, action 5 on Te Hiku Social Accord.		
2.4.2 Climate change	1 *Commitment.* Improved policies and commitment around sustainability and emission reduction.	Oct 2019, sustainability policy.	7% Greenhouse Gas emission reduction in 2020 compared with 2016 (leading up to 15% in 2025).
	2 *Transport* 2a Undertake the first travel survey.	Sep 2019, travel survey results.	
	2b Increase fleet e-bikes and bikes.	Oct 2019, Increase in low emission and active transport assets.	
	2c Improve active travel information.	Feb 2020, comms on intranet.	
	2d Reassess increase in EVs.	June 2020, Increase in low emission and active transport assets.	
	3 *Buildings.* Include green building criteria in building projects. Design review of building.	Feb 2020, review report designed.	
	4 *Energy.* Continue implementation of energy action plan.	June 2020, 3 energy action plan measures implemented.	
	5 *Procurement.* Ongoing assessment and implementation of environmentally preferred products.	June 2020, 2 environmentally preferred product changes.	
	6 *Certification.* Annual carbon footprint calculation.	Dec 2019, carbon footprint report published.	
2.4.3 Waste disposal	1 *Recycling infrastructure* 1a Complete implementation of recycling bins from 60% to 100%. 1b Implement available product stewardship schemes and other reduction initiatives.	Feb 2020, basic recyclable streams diverted from landfill.	3% increase in recycling. 3% reduction in waste to landfill compared with 2018.
	2 *Contracts* Include criteria in upcoming waste tender to reduce waste to landfill, improve recycling rates and services, and improve monitoring.	Oct 2019, signed waste contract with reduction criteria.	
	3 *Communication and training* Continue waste training. Improve online information on recycling and disposal streams.	June 2020, online presence waste recycling streams.	

Priority	DHB activity	Milestone	Measure
2.4.4 Drinking water	Consider how Northland DHB can support the Public Health Unit to manage and mitigate public health risks identified from inadequate or unsafe drinking-water supplies. This support may include (but is not restricted to): • holding discussions with key figures in local councils, other government agencies, the business sector, and other key stakeholders • meeting regularly with its PHU to understand and support drinking water activities in the environmental health exemplar • supporting its PHU in its work with Māori communities to improve drinking water quality..	Discussion to occur at ELT during Q1.	
2.4.5 Healthy food and drink	1 Review and update the current NDHB evidence-based and peer-reviewed Healthy Food and Drink Policy to align with the National Healthy Food and Drink Policy.	30 Sept. 2019, draft updated and policy completed. 30 Dec 2019, updated policy approved by Board.	
	2 Develop an evidence-based and peer-reviewed policy on the provision of plant-rich food for the DHB food services.	30 Dec. 2019, Working Group formed with relevant expertise. Scoping framework developed. 30 March 2020, draft policy completed.	
	3 Develop an evidence-based and peer-reviewed position statement on obesity.	30 Dec. 2019, draft position statement completed. 30 March 2020, position statement approved by the Board.	
	4 Insert into all NGO contracts an expectation that they have healthy food and drink policies for all food and drink sold on site and/or provided to service users.	Reports to be provided in Q2 and Q4 on the number of early learning settings, primary, intermediate and secondary schools that have: • water-only (including plain milk) policies • healthy food policies, noting that healthy food policies should be consistent with MoH's Eating and Activity Guidelines	
2.4.6 Smokefree 2025	1 Implement a kaupapa Māori physical education programme with a focus on quit smoking messages for hapu mama in hapu wānanga, teen parent schools, alternative education and any other places with a high number of Māori mama attending.	Reduce the number of 'smoking status unknown' for Māori wāhine who smoke.	Reduce equity gap for Māori and especially hapu mama who smoke. Babies living in smokefree households at 6 months SLM.
	2 Support LMCs and Well Child Tamariki Ora providers to improve the quality of their data collection through face-to-face contact and education by the Smokefree Kaitiaki roles.	Smokefree Kaitiaki provide Hapu Mama Incentive Programme education and resources to LMCs and Stop Smoking	By Q2 2019/20, establish baseline data. By June 2020, increase the number of Māori pēpi living in smokefree

Priority	DHB activity	Milestone	Measure
	Now that the new data standard has been rolled out in Jan 2019: • improve data quality and collection of smoking status for households of infants at 6 weeks of age • increase enrolments of Māori and especially hapu mama to Stop Smoking Service. ***EOA***	practitioners.	households by 2%.
	3 Support the increase of referrals from LMCs and Well Child Tamariki Ora providers to stop smoking services.	Send Stop Smoking Service referral pathway to LMCs. Stop Smoking Service practitioners to acknowledge acceptance of referrals from LMCs. Reduce the number of 'smoking status unknown' for Māori wāhine who smoke.	Increase the % of Māori babies living in smokefree households at six weeks. Number of self-reported and co-validated quitters increases.
	4 Primary health continues to implement activities that focus on providing Māori and Pacific populations smoking brief advice (SBA).	SBA team monitors the equity gap for people in the high needs group who have had SBA, and any gap is brought to the attention of practices.	Between 2018/19 Q2 and 2019/20 Q4, increase Māori offered SBA by GP clinics from 82.4% to 84.4%, and Pasifika from 87.9% to 89.9%. ***EOA***
	5 Stop Smoking Service Coordinator monitors and drives performance of Stop Smoking Services to achieve quit targets.	Coordinator meets regularly with practitioners to monitor their progress.	Self-reported and Co-validate quits increase.

Priority	DHB activity	Milestone	Measure
2.4.7 Breast screening	1 Increase participation of eligible Pacific women from 60.5% to 70% for the year ending June 30 2020. Maintain or achieve target breast screening coverage for all ethnic groups. Please note Fale Pasifika Northland are involved in all activities.	Coverage is reached.	70% coverage for the year ended 30 June 2019. Increase coverage for Pacific women from 60.5% in 2018/19 Q2 to 70% by 2019/20 Q4. Maintain at least 70% coverage for other ethnic groups.
	1.1 Identify the gap in volumes required for 2019/20 to attain 70% coverage for eligible Pacific women in Northland. Identify and invite eligible women from phase two of the NDHB / BSA data match. • send enrolment invitation letters to eligible women • phone or home visit overdue women and those who have not responded to the letter; offer appointments and any support required.	Recruitment gap is identified in Q1. Number of eligible women identified by Q1. Letters sent and phone calls / home visits are complete by 30 Sep 2019 Q1. Review outcome – volumes screened in Q2.	
	1.2. Complete a Northland PHO data match to identify general practices with eligible new and overdue eligible women: • contact all practices with eligible women to explore joint recruitment and retention initiatives • tailor initiatives agreed with the individual practices • implement initiatives with general practices.	Data match complete and eligible women identified by 30 Sep 2019 Q1. Start October 2019 and complete end of Q3. Women are contacted and offered support to screening / appointments Q3 and Q4. Review volumes screened in Q4.	
	1.3 Develop a communications strategy for Pacific women • meet with the NDHB Communications Manager • finalise a communications strategy for Pacific women • implement plan.	Meeting held and the strategy / plan is finalised by end of Q2. Communications plan is implemented and complete by end of Q3.	
	2 Maintain or achieve target breast screening coverage for all ethnic groups. Continue Regional Coordination Group (RCG) planned strategy and activities as outlined in the Breast Screen Waitemata / Northland (WDHB / NDHB) RCG plan and extension is approved by the NSU until June 2020.	Coverage maintained by 30 June 2020.	
2.4.8 Cervical screening	Northland DHB will work with the new Primary Health Entity Mahitahi Hauora (2.5.1 Primary health care integration) to: Finalise the *Northland Cervical Screening Programme Action Plan 1 July 2019-30 June 2020*. This plan describes participation and equity targets from baseline data, and the actions defined within it support the achievement of these targets to: 1a achieve participation for at least 80% of women aged 25-69 years in the	Q1	Northland Cervical Screening Programme Action Plan 1 July 2019-30 June 2020 is finalised.
		Q2 and Q4	Mahitahi Hauora monitoring reports provide evidence of progress against the Northland Cervical Screening Programme Action Plan 1 July 2019-30 June 2020, and specifically against the

Priority	DHB activity	Milestone	Measure
	most recent 36 month period		participation and equity targets.
	1b ensure equity gaps are eliminated for priority group women.  Cervical Screening Plan 2019-20.docx 2 Determine how cervical screening can be prioritised within the new Mahitahi Hauora framework. This will include considering a risk based approach to meet the constraints of resources and clinical risk; that is, women who: • have never had a smear; or • whose last smear was high grade. 2 Determine whether the "Localities" model offers any further opportunity to promote cervical screening or remove barriers. 3 Review the systems of referrals to screening support services across Northland. Northland DHB will monitor this progress through regular monitoring reports.	Q4	Provide evidence of planning with Mahitahi Hauora to: • prioritise cervical screening • find opportunities in the localities model to promote cervical screening or remove barriers • review the systems of referrals to screening support services across Northland.

2.5 Better population health outcomes supported by primary health care

These linkages apply to all priorities under 2.5

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

Priority	DHB activity	Milestone	Measure
2.5.1 Primary health care integration	*2018/19 has seen significant planning and preparation of a new, innovative model of delivery of primary health and community services across Northland's district. Northland DHB has participated in a transformational change journey that will see a new single entity for contracting services that are informed by patient and whānau through locality based service provision. In December 2018, Northland DHB's Board adopted a policy to purchase primary care services through Te Kaupapa Mahitahi Hauora - Papa O Te Raki Trust and mandated it would become the sole Primary health organisation for Northland.*		
	1 Ensure that the new Primary Health Entity 'Te Kaupapa Mahitahi Hauora Papa O Te Raki Trust' (Mahitahi Hauora) is fully embedded across	Northland DHB will enter into three alliance led contracts with Mahitahi	

Priority	DHB activity	Milestone	Measure
	Northland. Mahitahi Hauora has become the single primary care contracting entity for Northland through collective input of the previous Northland Alliance 'Te Roopu Ka Ha Pai Oranga' which oversaw the establishment of Mahitahi Hauora. Mahitahi Hauora is now Northland's Alliance with the mandate to deliver change through direct oversight of funding decisions. It will: • have accountability for primary care health outcomes for all Northlanders, irrespective of their geographical location • have greater involvement of communities in funding and service planning • target resources and strengthen the approach to eliminating health inequities • strengthen and increase the efficacy of advocacy for urban and rural primary care across all of Northland, including establishing an appropriate forum to ensure resilient and sustainable rural health care • enable effective primary care investment decisions based on the full picture of general practice and the population's needs • implement best practice in primary care and manage the resulting change programs effectively • improve distribution of resources across Northland in a targeted manner • reduce cost in management and overheads • increase investment into general practices and primary care to improve patient care • improve performance of health initiatives, KPIs and targets for all Northlanders.	Hauora that will enable the principles of alliance to come to life through shared accountabilities and funding flexibilities. The contracts will be co-dependent and focus on three domains: • management, capability and capacity of Mahitahi Hauora • population health outcomes of all Northlanders with a focus on Māori and high needs • specified health services for discrete contract delivery.	
		By Q1, ensure that Mahitahi Hauora has the mandate to develop its whānau-centric model of locality development through: • PHOSA signed with Mahitahi Hauora • PHOSA agreements exited with legacy PHOs providers.	
		Transition of primary care contracts as applicable from legacy providers by ensuring complementary contracts are signed with Mahitahi Hauora, with measures aligning to priorities: ongoing throughout 2019/20.	
		Ensure that, by Q4, Mahitahi Hauora has focused workstreams in their annual plan acknowledging:: • workforce, including utilisation of nurses and pharmacists in rural areas • Neighbourhood Healthcare Homes • long term conditions including diabetes and COPD • youth wellbeing, including mental health • tamariki ora, mama and pēpē	
		Support the development of Mahitahi Hauora infrastructure and operational models that meet Northland DHB's requirements by establishing: • locality plans by Q4, including	

Priority	DHB activity	Milestone	Measure
		commitments to sustaining rural health care across Northland • shared quarterly reporting processes, responsibilities and accountabilities by Q1 and ongoing.	
		Shared annual planning and reporting processes in place between Northland DHB and Mahitahi Hauora by Q4. Baseline performance measures and improvement targets for health priority areas set by Q2.	
	2 Develop a new Northland Health Strategy that describes Northland DHB's future vision of healthcare. The Northland Health Strategy activity scheduled for 2018/19 has been rolled into the establishment of Mahitahi Hauora.	Work with Mahitahi Hauora to develop a Northland Health Strategy that will address, among other things, innovative and integrated workforces across primary care. Timeframes to be developed as part of the August 2019 project plan.	
	Improved service provision in urgent and afterhours care across Northland.		
	3 Undertake a review of after-hours provision across Northland in partnership with Mahitahi Hauora. 4 Implement strategies identified for improved patient access to acute need services.	By Q3, review of after-hours provision across urban and rural areas completed. Subject to resourcing and capability of Mahitahi Hauora, implement after-hours actions by Q4.	
		By Q2, improved integration of primary care and secondary care by growing the Primary Options Acute Demand Management Services (POADMS) in line with patient and system need.	Through supporting POADMS, reduce by 3% the rate of hospital readmission for adults with chronic respiratory conditions who reside in area identified as quintile 4 or 5, and are of Māori/ Pacific ethnicity. ***EOA***
		By Q2, implement a 'Northland Initiative' under the direction of a Clinical Director for Acute Demand that addresses system changes to meet patient needs and leads system change from a clinical perspective.	

Priority	DHB activity	Milestone	Measure
	Assist in the utilisation of other workforces in primary health care settings. Refer to 2.5.1 Primary health care integration		
	5 Commence the tranche 3 roll out of the Neighbourhood Healthcare Homes programme. Once completed the total number of patients enrolled with an NHH practice will be 117,000.	By Q4, progressive rollout of Tranche 3 .with capitation contracts in place.	
	6 Progress the Health and Social Care Coordination Programme, strengthening opportunities for integration across primary, community (government, NGO and voluntary sector) and secondary care. Achieved by: • Multidisciplinary Team Meetings (Standards) • Care Coordination Networks • Northland Community Hub (centralised triage process) • workforce capacity and capability building – the Calderdale Framework.	By Q2, embed two agreed standards (virtual and face-to-face) for primary care-led multidisciplinary team meetings.	Audit of MDT meetings focusing on: • meeting protocol adherence • # MDTs involving general practice completed • participants in patients' named care teams (by professional group); • care plans with recorded decision and actions following the MDT and • patient/ whānau-related outcomes • patient/ whānau and provider experience.
		By Q2, primary and community health and social care networks established across the Northland region in defined geographic localities, working together with primary care to optimise utilisation and coordination of available community health and social care resources for the benefit of patients.	Range of providers and services participating in local networks. Evidence messaging/ information exchange using Whānau Tahi. % increase Whānau Tahi Shared Care Plans with named care team members outside the general practice. % increase in referrals received from general practices by NDHB community nursing and allied health services. % increase of referrals received from general practices by a specified group of NGO and voluntary sector services. Patient/ whānau and provider experience.
		By Q2, establishment of a central point of referral, triage and scheduling of in-scope community nursing and allied health services, to be called Northland Community Hub.	% increase in average time clinicians spend providing face-to-face services to patients. % reduction in triage duplication. % decrease in declined referrals. % reduction in average waiting time from referral to first assessment.
		By Q2, introduction of the Calderdale	10 Allied Health and District Nursing

Priority	DHB activity	Milestone	Measure
		Framework (CF) (task delegation and skills sharing) to Allied Health and District Nursing services across Northland.	professionals trained as CF Facilitators with the ability to delegate tasks to HCAs and share clinical skills between nursing and allied health workforce. 10 CF workforce redesign projects initiated, planned and in implementation phase. Governance and training structures in place to support the ongoing application of the CF in Northland.
2.5.2 Pharmacy	1 Support the vision of the Pharmacy Action Plan 2016-2020 and the Integrated Community Pharmacy Services Agreement (ICPSA) through the implementation of a Northland Community Pharmacy Strategy. This strategy will support: • improved influenza vaccination rates for Māori, Pacific and Asian people aged over 65 years • separation of dispensing into the ICPSA schedules • extended roles for pharmacies as a local clinical hub.	Community pharmacy strategy released in Q1. The strategy includes milestones for the purchase of schedule 3 services, including: • what we will do in community pharmacy to improve influenza vaccination rates for Māori, Pacific and Asian people aged over 65 years • how we will purchase local schedule 3 clinical pharmacy services based on need. By Q3, action plan for increasing influenza vaccinations in Māori, Pacific and Asian people over 65 years of age from 1 April 2020 is developed and reported. This plan includes commitment to report on outcomes by Q2 2020/21.	
		Purchase of schedule 3 services in line with the strategy, and in consultation with Te Kaupapa Mahitahi Hauora – Papa O Te Raki Trust by Q4 to promote further integration of primary care and pharmacy.	
		Implementation of an ICPSA contracting policy, to determine under which conditions ICPSA will be issued. Any new applications for ICPSA processed as per new contracting policy from Q1.	
		Identify lessons for pharmacy from the Meningitis W vaccination campaign, and	Subject to Pharmac approval, through the delivery of vaccination services in

Priority	DHB activity	Milestone	Measure
		take advantage of any opportunities to extend pharmacy services, particularly for vaccinations and contraception. Where opportunities exist, implement extended services in community pharmacies from Q1 and ongoing.	community pharmacy, increase pertussis immunisations in the 28-38 week period of gestation for pregnant Māori women (hapu mama) by 10% in a 12 month period. ***EOA***
2.5.3 Diabetes and other long-term conditions	1 Subject to funding, The new Green Prescription model (contract to be executed in Q1), includes specific actions to distribute resources to promote prevention, contribute to a reduction of inequities, and support better self-management.	Revised Green Prescription contract in place with provider, signed by Q1. Green Prescription contract milestones met.	
	2a Ensure diabetes and other long term conditions are key focus areas for Mahitahi Hauora. This will include enhancement under Mahitahi Hauora's strategic priority for improving health outcomes for people living with diabetes through reconfigured focus on public health promotion and self-management activities. This will be monitored through regular contract reporting.	By Q4.	
	2b Northland DHB will work with Mahitahi Hauora to implement a new diabetes self-management education (DSME) model.	By Q4.	
	3 Subject to funding, work with Diabetes New Zealand to extend its services into Northland, and ensure these services include public health promotion, and target equity of access to diabetes self-management and support.	By Q3: conversations will progress with Diabetes New Zealand to implement a model consistently across Northland.	
	4 Northland DHB will enter into a contract with Mahitahi Hauora that has a specific focus on outcomes for people living with diabetes.	Q2: reporting and outcomes requirements will be agreed. Q4: baseline data will be recorded to enable quality improvement methodologies to be implemented in 2020/21.	
	5 Improve patient access to and experience of diabetes annual reviews (DAR) and cardiovascular disease risk assessments (CVDRA).	By Q2, workplan developed and implemented to improve access to and experience of DARs and CVDRAs. Implementation of milestones identified in the plan started by Q4.	For Māori patients with diagnosed diabetes, increase the proportion with good control (HbA1c<64mmol/mol) from 61% at 30 September 2018 to 65% by 30 June 2020. ***EOA***

2.6 Financial performance summary

Statement of Comprehensive Income $000s	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
DHB Provider Revenue	361,533	393,972	412,316	428,808	445,961	463,799
DHB Funder Revenue	272,492	291,270	299,749	311,739	324,208	337,177
DHB Governance & Administration	368	(0)	(0)	(0)	(0)	(0)
Inter District Flow Revenue	9,907	10,881	11,195	11,643	12,109	12,593
Total Revenue	644,300	696,123	723,260	752,190	782,278	813,569
DHB Provider Operating Expenditure	348,444	392,896	399,302	415,267	432,241	450,742
DHB Non Provider Funded Services	204,422	213,180	226,493	235,553	244,975	254,774
DHB Governance & Administration	325	347	583	606	630	656
Inter District Flow Expense	80,367	84,181	85,019	88,420	91,957	95,635
Total Operating Expenditure	633,559	690,604	711,397	739,846	769,802	801,806
Earnings before Interest, Depreciation, Abnormals & Capital Charge	10,742	5,519	11,863	12,344	12,475	11,763
Less						
Interest on Term Debt	71	126	469	487	507	527
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Earnings before Abnormals & Capital Charge	(2,322)	(8,637)	(3,669)	(3,809)	(4,324)	(5,708)
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	(2,322)	(8,637)	(3,669)	(3,809)	(4,324)	(5,708)
Capital Charge	8,465	9,282	9,131	9,503	9,520	8,690
Surplus (Deficit)	**(10,787)**	**(17,919)**	**(12,800)**	**(13,312)**	(13,844)	(14,398)
Revaluation of Fixed Assets	(20,602)	0	0	0	0	0
Comprehensive Income	**9,815**	**(17,919)**	**(12,800)**	**(13,312)**	**(13,844)**	**(14,398)**

Statement of Movements in Equity $000s	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Equity at the beginning of the period	149,763	159,561	148,248	154,446	154,737	140,893
Surplus/Deficit for the period	(10,787)	(17,919)	(12,800)	(13,312)	(13,844)	(14,398)
Total Recognised Revenues and Expenses	138,976	141,641	135,448	141,135	140,893	126,495
Other Movements						
Revaluation of Fixed Assets	20,603	-	-	-	-	-
Other	(18)	7	- 2	2	-	-
Equity introduced (Repaid)	-	6,600	19,000	13,600	-	-
Equity at end of Period	**159,561**	**148,248**	**154,446**	**154,737**	**140,893**	**126,495**

Statement of Financial Position

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Equity						
Crown Equity	65,005	65,005	71,605	90,605	104,205	104,205
Retained Earnings	(8,396)	(26,315)	(39,116)	(52,427)	(66,271)	(80,670)
Subsidiaries & unrestricted trusts	208	215	215	215	215	215
Revaluation Reserve	102,743	102,744	102,744	102,744	102,744	102,744
Equity Injections	-	6,600	19,000	13,600	-	-
Total Equity	159,561	148,248	154,448	154,737	140,893	126,494
Represented by:						
Assets						
Current Assets	30,706	31,308	26,232	26,232	26,232	26,232
Non-Current Assets	227,087	234,545	253,864	263,068	258,047	253,895
Total Assets	257,792	265,854	280,095	289,300	284,278	280,127
Liabilities						
Current Liabilities	83,300	98,396	107,030	116,535	125,823	136,412
Non-Current Liabilities	14,931	19,210	18,618	18,029	17,564	17,221
Total Liabilities	98,231	117,606	125,648	134,564	143,386	153,633
Net Assets	**159,561**	**148,248**	**154,448**	**154,736**	**140,892**	**126,494**

Statement of Cash Flows

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Cash Flows from Operating Activities						
Operating Income	644,966	690,730	725,207	751,982	782,061	813,345
Operating Expenditure	632,610	684,233	725,146	749,349	779,323	810,496
Net Cash from Operating Activities	12,355	6,496	61	2,633	2,738	2,849
Cash Flows from Investing Activities						
Interest receipts 3rd Party	841	601	200	208	216	225
Sale of Fixed Assets	22	18	-	-	-	-
Purchase of Fixed Assets	(16,996)	(22,805)	(33,641)	(24,870)	(11,270)	(12,793)
(Increase)/Decrease in Investments and Restricted & Trust Funds As	(1,707)	(1,629)	(740)	(0)	(0)	(0)
Net Cash from Investing Activities	(17,840)	(23,815)	(34,181)	(24,662)	(11,054)	(12,568)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	6,600	19,000	13,600	-	-
Borrowings introduced (repaid)	(712)	7,320	(898)	(589)	(465)	(343)
Interest Paid	(71)	(126)	(469)	(487)	(507)	(527)
Other Non-Current Liability Movement	-	(2)	-	-	-	-
Net Cash from Financing Activities	(783)	13,792	17,633	12,524	(972)	(870)
Net Increase/(Decrease) in Cash held	(6,267)	(3,526)	(16,487)	(9,505)	(9,287)	(10,589)
Add opening cash balance	12,707	6,439	2,913	(13,574)	(23,079)	(32,367)
Closing Cash Balance	6,439	2,913	(13,574)	(23,079)	(32,367)	(42,956)

Note: *Cash balance includes short term investments which are considered cash or cash equivalents*

Key Financial Analysis and Banking Covenants

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	98,231	117,606	125,648	134,564	143,386
Debt	1,775	9,095	8,197	7,608	7,143
Owners Funds	159,561	148,248	154,448	154,736	140,892
Total Assets	257,792	265,854	280,095	289,300	284,278
Owners Funds to Total Assets	61.9%	55.8%	55.1%	53.5%	49.6%
Interest Expense	71	126	469	487	507
Depreciation Expense	12,993	14,030	15,063	15,665	16,292
Surplus/(Deficit)	(10,787)	(17,919)	(12,800)	(13,312)	(13,844)
Interest Cover	32.24	- 29.94	5.83	5.83	5.83
Debt/Debt + Equity Ratio	1%	6%	5%	5%	5%
Banking Covenants					
Debt/Debt + Equity Ratio	1.1%	5.8%	5.0%	4.7%	4.8%
Interest Cover	32.2	- 29.9	5.8	5.8	5.8
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Devolved Funding	605,727	655,769	685,705	713,133	741,658	771,325
MOH Non-Devolved Contracts (provider arm side contracts)	14,471	15,556	14,789	15,381	15,996	16,636
Other Government (not MoH or other DHBs)	7,185	6,778	6,393	6,648	6,914	7,191
Patient / Consumer sourced	637	834	449	466	485	505
Other Income	5,048	5,052	3,539	3,681	3,828	3,981
InterProvider Revenue (Other DHBs)	1,326	1,253	1,190	1,238	1,287	1,339
IDFs - All Other (excluding Mental Health)	9,907	10,881	11,195	11,643	12,109	12,593
Total Consolidated Revenue	644,300	696,123	723,260	752,190	782,278	813,569
Personnel Costs	235,137	268,710	277,190	288,277	299,809	311,801
Outsourced Services	34,736	40,343	35,641	37,066	38,549	40,091
Clinical Supplies	49,767	52,956	54,877	61,655	64,121	66,686
Infrastructure & Non-Clinical Supplies	29,130	31,234	32,177	28,875	30,392	32,820
Finance Costs	8,535	9,408	9,600	9,991	10,027	9,217
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Personal Health	186,749	195,810	202,212	210,301	218,713	227,461
Mental Health	15,964	16,841	19,956	20,754	21,584	22,448
Disability Support Services	74,638	77,546	81,201	84,450	87,828	91,341
Public Health	1,734	1,722	1,790	1,862	1,936	2,014
Maori Health	5,704	5,442	6,352	6,606	6,870	7,145
Total Operating Expenditure	655,087	714,042	736,059	765,502	796,122	827,967
Surplus (Deficit)	**(10,787)**	**(17,920)**	**(12,800)**	**(13,312)**	**(13,844)**	**(14,398)**

Provider Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	14,471	15,556	14,789	15,381	15,996	16,636
Other Government (not MoH or other DHBs)	6,825	6,778	6,393	6,648	6,914	7,191
Non-Government & Crown Agency Sourced	5,685	5,886	3,988	4,147	4,313	4,485
InterProvider Revenue (Other DHBs)	1,326	1,253	1,190	1,238	1,287	1,339
Internal Revenue (DHB Fund to DHB Provider)	333,227	364,498	385,956	401,394	417,450	434,148
Total Provider Revenue	361,533	393,972	412,316	428,808	445,961	463,799
Personnel Costs	235,137	268,710	277,190	288,277	299,809	311,801
Outsourced Services	34,736	40,343	35,641	37,066	38,549	40,091
Clinical Supplies	49,767	52,956	54,877	61,655	64,121	66,686
Infrastructure & Non-Clinical Supplies	28,804	30,888	31,594	28,269	29,762	32,164
Finance Costs	8,535	9,408	9,600	9,991	10,027	9,217
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Total Operating Expenditure	369,973	416,334	423,964	440,923	458,560	476,902
Surplus (Deficit)	**(8,439)**	**(22,362)**	**(11,649)**	**(12,115)**	**(12,599)**	**(13,103)**

Governance Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Government & Crown Agency Sourced	368	(0)	(0)	(0)	(0)	(0)
Total Governance Revenue	368	(0)	(0)	(0)	(0)	(0)
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	325	347	583	606	630	655
Total Operating Expenditure	325	347	583	606	630	655
Surplus (Deficit)	**43**	**(347)**	**(583)**	**(606)**	**(630)**	**(655)**

Funder Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Devolved Funding	605,727	655,769	685,705	713,133	741,658	771,325
Inter District Flows	9,907	10,881	11,195	11,643	12,109	12,593
Total Funder Arm Revenue	615,994	666,649	696,900	724,776	753,767	783,918
Personal Health	470,476	507,191	535,594	557,017	579,298	602,470
Mental Health	58,193	62,125	64,696	67,284	69,975	72,774
Disability Support Services	80,913	84,407	88,063	91,585	95,249	99,059
Public Health	2,504	2,362	2,431	2,528	2,629	2,734
Maori Health	5,929	5,774	6,685	6,953	7,231	7,520
Other	368	-	-	-	-	-
Total Operating Expenditure	618,384	661,859	697,468	725,367	754,382	784,557
Surplus (Deficit)	**(2,390)**	**4,790**	**(568)**	**(591)**	**(614)**	**(639)**

3 Service Configuration

3.1 Service Coverage

The Ministry of Health's Service Coverage Schedule specifies the services a DHB must ensure are provided. This section deals with any significant exceptions that might be sought. Northland DHB seeks no such exceptions.

3.2 Service Change

If any service changes do arise, we will follow the Service Change Protocols in the Operational Policy Framework. We will notify the National Health Board of any service changes resulting from planned service reviews or that may arise during the year.

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Single primary health entity.	Northland DHB will enter into a single Primary Health Organisation Services Agreement (PHOSA) with Te Kaupapa Mahitahi Hauora – Papa O Te Raki Trust on 1 July 2019. In partnership with existing providers, Northland DHB will also identify any applicable contracts that may be affected by the implementation of the Trust with a view to transitioning them in a planned manner that meets the objectives of the single primary health entity. Service changes that will be reviewed include: • current contracts between Northland DHB and the incumbent PHO providers • review of provision of acute primary care services • further integration across the Northland health system • improve access to primary and community care services across Northland.	Provide accountability for primary care health outcomes for all Northlanders, irrespective of their geographical location. Greater involvement of communities in funding and service planning. Target resources and strengthen the approach to eliminating health inequities. Strengthen and increase the efficacy of advocacy for urban and rural primary care across all of Northland. Enable effective primary care investment decisions based on the full picture of general practice and the population's needs. Implement best practice in primary care and manage the resulting change programs effectively. Improve distribution of resources across Northland in a targeted manner. Reduce cost in management and overheads. Increase investment into general practices and primary care to improve patient care. Improve performance of health initiatives, KPIs and targets for all Northlanders.	Local
Community Pharmacy	Northland DHB will implement a new Community Pharmacy Services Strategy and	Improve distribution of pharmacy services across	National and

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Services Strategy	resulting procurement policy. The strategy will: • align to the Pharmacy Action Plan and New Zealand Health Strategy • focus on improving population health outcomes, enhancing access to pharmacists as medicines management experts • describe the circumstances in which Northland DHB will enter into new Integrated Community Pharmacy Services Agreements • reference how Northland DHB will utilise funding for pharmacy services into the future to meet the needs of the strategy • inform a purchasing policy that complies to the strategy.	Northland in a targeted manner to meet health requirements. Improve health outcomes through clinically delivered pharmacy services that demonstrate continuous quality improvement. Encourage innovation in pharmacy services delivery. Investigate how community pharmacy services align to the development of locality based models delivered through Te Kaupapa Mahitahi Hauora – Papa O Te Raki Trust. Develop integrated primary care services across Northland. Implement the Pharmacy Action Plan. Set a purchasing policy for clinical pharmacy services that improves patient health outcomes.	local
Māori Health Services Review	Post community engagement in Te Tai Tokerau with whānau, establish a working group with Māori health providers and Iwi technical advisors to oversee the redesign of health services. Design models of care that align with the community engagement feedback. Reallocate existing Māori health resources to support the change. Link Commissioning for Outcomes project to the Māori Health Services Review. Design of services will be population health outcomes focused to achieve improved health outcomes for Māori whānau. New services to be phased in from 2020.	Redesign of services to meet the needs of whānau in Te Tai Tokerau. Reinvestment into health priorities, targeting child and youth and kaumātua/ kuia. Opportunity to support innovative models of care in service design and delivery.	

3.3 Ability to enter into service agreements

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

- negotiate and enter into service agreements containing any terms and conditions that may be agreed
- negotiate and enter into agreements to amend service agreements.

4 Stewardship

4.1 Managing our business

4.1.1 Organisational performance management

Northland DHB has clear lines of accountability for reporting and monitoring that are captured in position descriptions. Reports on management performance are provided monthly, quarterly and annually and presented at various venues including the Board, ELT, Clinical Governance, Medical ELT, and the Organisational Management Group.

Northland DHB has an ELT dashboard that is continually being improved and refreshed.

Processes for specific areas of operation are described in more detail in 4.1.2 to 4.1.6.

4.1.2 Funding and financial management

Northland DHB's finances are thoroughly monitored both internally and by external agencies.

Internally:

- our financial management systems enable us to set targets and monitor performance on finance, workforce and service delivery
- monthly Internal Planning, Performance Monitoring and Reporting meetings monitor finance and other performance based on the targets set above
- financial reports and reviews occur at the Board's Audit and Risk Committee, and at Board meetings
- delegated authorities are reviewed annually and approved by the Board.

Externally:

- MoH monitors our financial performance through the reports we send them monthly
- once a year Audit NZ audits our financial statements and our Annual Report
- the regional internal audit service audits and monitors our financial systems and performance, as well as those of the Northern Region's shared service agency healthAlliance
- healthAlliance provides regional oversight of information systems and technology, and NZ Health Partnerships was established nationally to save money by reducing administrative, support and procurement costs.

Our infrastructure, clinical equipment and information systems investment portfolios are each governed by a steering group comprising clinical staff, consumer representatives and management. NDHB is currently in the process of embedding the P3M3 framework to support our programme management.

4.1.3 Investment and asset management

Northland DHB is a Tier 2 Intensive Investment Agency under Treasury's Investment Management and Asset Performance (IMAP) with a Cabinet-approved Investor Confidence Rating of 'C' based on the assessment undertaken in 2016. The rating reflects Northland DHB's ability to manage investment portfolios and to successfully deliver promised benefits in the medium and long term. A review of The Northern Regional Health Plan with a focus on primary and secondary integration is currently underway to update this document with approved strategic goals aligning to Ministry of Health priorities, NZ Health Strategy, Northland DHB planning documentation and the Long Term Investment Plan. Northland's long term intentions include the redevelopment of the Whangārei Hospital campus and an electronic health record covering primary and secondary services.

A second Treasury lead Investor Confidence Rating assessment is underway in the first half of 2019 which will include a complete review and update to Asset Management Plans, Polices, Strategy and the Long Term Investment Plan.

4.1.4 Shared service arrangements and ownership interests

The Northland DHB group consists of the parent, Northland DHB, and Kaipara Joint Venture Trust (51% ownership by Northland DHB). Northland DHB has a joint venture with the other Northern Region DHBs in healthAlliance NZ Limited (25%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

4.1.5 Risk management

Northland DHB manages its risk through a Risk Committee that provides oversight and management of all risks. The Risk Committee provides an in-depth appraisal and management of corporate risks each month, and prepares a report to the Operational Management Group that provides governance of risk. The Risk Committee delivers monthly reports to the Finance, Risk and Audit Committee. The Emergency and Corporate Risk Manager attends these meetings and provides any updates and clarifications that may be needed for the Board members.

The governance of risk is managed in the following way:

- a clear risk policy that all staff are made aware of
- a guide for staff on how to appropriately identify and manage risks
- monthly review of the high to extreme risks in Datix
- a monthly Risk Committee meeting to review the top risks and identify management plans where necessary
- monthly reporting to the Operational Management Group
- monthly reporting to the Finance, Risk and Audit Committee.

4.1.6 Quality assurance and improvement

Our commitment to quality and safety aligns with the national vision and includes:

- six-weekly quality reports produced for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Clinical Governance Board
- monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems
- a dedicated clinical audit position that is supported by the Clinical Audit Committee
- robust documents control process to ensure high quality of policies, procedures, processes and patient information
- an electronic risk register so all parts of the organisation can record and manage risk
- a Patient Safety and Quality Improvement framework, a commitment to our patients/clients, staff and community to improve quality through focused targets and actions.
- coordination of and support for the Consumer Council
- monitoring and driving improvement for established national quality safety markers
- incorporation of equity in all we do.

4.1.7 Partnership with Public Health

Northland DHB will work in partnership with our public health unit in their work on promoting and protecting population and environmental health, delivering services that improve the effectiveness of prevention activities in other parts of the health system, cross-sectorally, and in undertaking regulatory functions.

4.2 Building capability

4.2.1 Capital and infrastructure development

Northland DHB received approval on 30 May 2017 from the Capital Investment Committee (CIC) to develop a programme business case for a major redevelopment of Whangārei Hospital. The aim of the redevelopment will be to transform health services in Northland with a focus on service and campus redesign. Interim projects currently underway or in planning stages include an Endoscopy Theatre, Additional Theatre Capacity, a Cardiac Cath Lab, Bay of Islands Redevelopment Stage 2 and Community Mental Health.

The Programme Business Case for the Whangārei Hospital Redevelopment has now been placed on hold by Ministry due to funding constraints. A second Business Case for capacity and critical compliance will be submitted to the CIC in April. Further business cases for Community Mental Health; condition and health and safety will follow.

BECA has been engaged for a condition assessment on the main Whangārei Hospital. The assessment will focus on fitness for purpose, structure and fire compliance. Results from the assessment will help inform the capacity and critical compliance Business Case.

NDHB allocates budget to baseline Facilities Minor Works and Clinical Equipment in the Annual Plan.

Annual capital bid approval processes see bids rated and prioritised by Capital Planning and Review Committees. This informs the makeup of the clinical equipment and buildings baseline funding allocation. Of the clinical equipment budget, 20% is set aside as breakdowns to ensure there is immediate funding available to replace clinical equipment which breaks down during the year. The fund also covers the scenario where the cost of equipment repair is no longer viable or the equipment cannot be repaired. Major Clinical Equipment projects, for example MRI or Patient Monitoring, are detailed a separate projects in the Annual Plan.

Northland DHB is to review Facilities and Clinical Equipment asset management plans in the first half of 2019. The results will assist prioritisation processes.

4.2.2 IT and communications systems

The Northern Region has developed its Long Term Investment Plan (LTIP) to provide an investment path for the region to address its key healthcare delivery issues around capacity and capability. A key element of the LTIP is the information systems strategic plan (ISSP), including the roadmaps that support its delivery. The Northern Region ISSP is fully aligned with the National Health Strategy and the Ministry of Health's Digital Strategy, and this alignment has been detailed in the ISSP which has been reviewed by the Ministry of Health. The four key investment objectives in the ISSP are to strengthen our ICT foundations, simplify our layers of applications, become experts at interoperability, and become a capable region.

Strengthening our ICT foundations. The scope of this includes moving our infrastructure to the all-of-government private cloud datacentres, developing a robust telecommunications capability, identity and access management, moving to Windows 10 / Office 365, and developing our hybrid cloud approach and capability.

Simplify our layers of applications. Within this investment stream, the implementation of an Application Portfolio Management (APM) tool is complete. It is planned to commence the analysis of the results that will be accumulated by this tool as from January 2019, and these results will be used to support a number of initiatives focused on application stabilisation, as well as the replacement of ageing systems. It is expected that these initiatives will support the ISSP strategy in its objectives to rationalise, standardise, and simplify the number and diversity of applications wherever possible. It is expected that this process will extend to 2024, that is,to accommodate the larger investments in transforming major application sets, such as those involved in HARP, RCCC, and HIP.

Interoperability. We will grow our capability through embedding the MuleSoft Application programme interface (API) capability, and beginning the design of our regional data sharing and health information platform.

Become a capable region. Our focus in growing our regional capabilities includes further developing our P3M3 and business case capabilities as well as continuing to invest in innovation and digital acceleration.

4.2.3 Workforce

Organisational culture and workforce development

Staff wellbeing continues to be an organisation priority. Additional programmes will be implemented to support employee mental health and wellbeing, violence prevention, employee engagement, and

leadership development. The organisation's Values will also be updated to reflect the importance of the employee experience.

We will attract, recruit and develop a talented workforce. An updated employee value proposition and branding will be implemented, along with a new role to advance the recruitment of Māori candidates. We will continue to grow the capacity and capability of our Māori workforce, with new programmes including a new Māori staff development symposium.

We will continue to reshape the workforce to deliver innovative care and integrate models of care in responding to changing population needs. District Nursing and Allied Health workforce capacity and capability strategies will be enhanced through the implementation of the Calderdale Framework, enabling tasks to be shared between roles. To support innovation there will also be increased opportunity for staff research coordinated through a new hub.

Leadership

Strong leadership is paramount for the overall effectiveness of Northland DHB and is encouraged and supported at all levels of the organisation. Leaders do not have all the answers nor do they need to. What leaders must strive for is to unlock the potential of our highly skilled staff by providing what they need to perform their roles successfully.

Northland DHB has adopted the State Services Commission Leadership Success Profile (LSP). The LSP establishes 'what good looks like' for leadership at all levels. There are five core dimensions of the LSP:

- navigating for the future
- stewardship – of people, functions, organisations and systems
- making it happen – with and through others
- identifying and developing talent
- leadership character.

Over the next year and beyond, Northland DHB is committed to implementing our LSP-based leadership programme. In addition to the five core dimensions Northland DHB recognises that leadership does not sit in isolation but is a critical to achieving and supporting the organisation's future direction.

Key requirements underpinned by leadership and the organisation's Values include:

- achieving equity
- staff wellbeing
- fostering a highly engaged workforce
- growing the capacity and capability of our Māori workforce
- attracting, recruiting and developing a talented workforce
- ability to reshape the workforce to deliver innovative and integrated models of care in response to changing population needs.

Active engagement with the organisational-wide leadership programme is a 2019/20 priority that will be regularly reported to the Executive Leadership Team. Capturing LSP competencies into the existing HR information system will be explored, as will connecting to national talent management systems.

Māori workforce development

Northland DHB is committed to developing the Māori workforce across the organisation (2.3.12a Workforce priorities and 2.3.12b Workforce diversity). We will:

- grow the capacity and capability of our Māori workforce
- recruit more Māori professionals and more Māori into the workforce generally
- to achieve this, implement the positive discrimination process contained in policy, align to ELT targets and appoint a Workforce Equity Manager
- strengthen cultural competency across the workforce
- improve information to more accurately and completely capture ethnicity among the workforce, and to make Māori participation more visible in reporting.

4.2.4 Cooperative developments

the Northland Intersectoral Forum (NIF) comprises local and central government agencies working in a collaborative way to make a positive difference to the wellbeing of Northlanders; its vision is to ”accelerate solutions to complex challenges through collaborative action”. NIF has four subgroups:

- rangatiratanga (economic development)
- kaitiakitanga (environment)
- ora (health and social)
- matauranga (education).

NIF intends to reconstitute its Social Wellbeing Governance Group now that the Northland-wide Kainga Ora contract has been terminated. This will allow Northland to focus on the social wellbeing issues that Northlanders need to address including youth suicide, family violence, high need children and families.

Northland DHB is also involved in the governance and funding of Otangarei Kainga Ora, an ongoing place-based project in a suburb of Whangārei.

5 Performance measures

Performance measure		Expectation		
Improving child wellbeing				
CW01	Oral health: children caries free 0-4 years of age	Year 1 Year 2	46% 46%	
CW02	Oral health: mean DMFT score at school year 8	Year 1 Year 2	0.94 0.94	
CW03	Improving the number of children enrolled and accessing the community oral health service	Measure 1, ages 0-14	Year 1 Year 2	≥95% ≥95%
		Measure 2, preschool and primary school children overdue for their scheduled examinations	Year 1 Year 2	≤10% ≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1 Year 2	≥85% ≥85%	
CW05	Immunisation coverage at eight-month-oldsand 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 and over	95% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. The equity gap, if any, between Māori and non-Māori populations is no more than 2%.		
		95% of five year olds fully immunised		
		75% of girls and boys fully immunised with HPV vaccine		
		75% of 65+ year olds immunised with flu vaccine		
CW06	Breastfeeding	70% of infants are exclusively or fully breastfed at three months		
CW07	Newborn enrolment with general practice	55% of newborns enrolled in general practice by 6 weeks of age		
		85% of newborns enrolled in general practice by 3 months of age		
CW08	Increased immunisation, 2-year-olds	95% of two year olds fully immunised9		
CW09	Better help for smokers to quit, maternity	90% 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		
CW10	Raising healthy kids	95% 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		
CW11	Supporting child wellbeing	Provide report as per measure definition		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities, and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS		
		Initiative 3: Youth primary mental health		
		Initiative 5: Improve the responsiveness of primary care to youth; report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve the health of the DHB's youth population		
CW13	Reducing rheumatic fever	Reduce the Incidence of first episode rheumatic fever to 3.5 per 100,000		
Improving mental wellbeing				
MH01	Improving the health status of people with	Age 0-19 Māori	5.11%	

Performance measure		Expectation	
	severe mental illness through improved access	Other Total	4.34% 4.74%
		Age 20-64 Māori Other Total	 10.22% 4.17% 6.07%
		Age 65+ Māori Other Total	 2.22% 1.83% 1.88%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan	
		95% of audited files meet accepted good practice	
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks
			95% of people seen within 8 weeks
		Addictions (provider arm and NGO)	80% of people seen within 3 weeks
			95% of people seen within 8 weeks
MH04	Rising to the Challenge: 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 at least 10% by the end of the reporting year	
MH06	Output delivery against plan	Volume delivery for specialist mental health and addiction services is: within 5% variance of planned volumes for services measured by FTE 5% variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed days actual expenditure on the delivery of programmes or places is within 5% of the year-to-date plan	
Improving wellbeing through prevention			
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall	
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall	
Better population health outcomes supported by strong and equitable public health services			
SS01	Faster cancer treatment, 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	
SS02	Ensure delivery of Regional Service Plans	Provide reports as specified	
SS03	Ensuring delivery of service coverage	Provide reports as specified	
SS04	Delivery of actions to improve wrap-around services for older people	Provide reports as specified	
SS05	Ambulatory sensitive hospitalisations, adult, rate per 100,000 unstandardised	Total	4,799

SS07	Planned Care	Measure 1, minimum number of planned care interventions		Inpatient surgical discharges 8,467 Minor procedures 3,858 Non-surgical interventions 100 Total 12,425	
		Measure 2: Elective Service Patient Flow Indicators	ESPI 1: DHB services that appropriately acknowledge and process more than 90% of referrals in 15 calendar days or less	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)	
			ESPI 2: Patients waiting longer than four months for their first specialist assessment (FSA)	0% – no patients are waiting over four months for FSA	
			ESPI 3: Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT)	0% - zero patients in Active Review with a priority score above the aTT	
			ESPI 5: Patients given a commitment to treatment but not treated within four months	0% - zero Assured patients are waiting over 120 days for treatment	
			ESPI 8: The proportion of patients who were prioritised using approved nationally recognised processes or tools	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool	
		Measure 3: Diagnostics waiting times	Coronary angiography: 95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) Computed tomography (CT): 95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days). Magnetic resonance imaging (MRI): 90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).		
		Measure 4: Ophthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment.		
		Measure 6, acute readmissions, 28 days standardised	11.7%		
SS08	Planned Care three-year plan	Provide report as specified			
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (duplication)	>1% and ≤3%	
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%	
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%	
			Validated addresses excluding overseas,	>76% and < or equal to	

			unknown and dot (.) in line 1	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	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours		
SS11	Faster cancer treatment, 62 days	90% 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		
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	Report on actions to support people with LTC to self-manage and build health literacy	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity	
		Focus Area 3: Cardiovascular health	Provide reports as specified	
		Focus Area 4: Acute heart service	Indicator 1, door to cath: door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram	
			Indicator 2, registry completion 2a: >95% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge 2b: ≥ 99% within 3 months	
			Indicator 3, ACS LVEF assessment: ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (that is, have had an echocardiogram or LVgram)	
			Indicator 4, composite post ACS secondary prevention medication indicator: 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*, statin and an ACEI/ARB (4 classes), and	

			LVEF<40% should also be on a beta-blocker (5-classes). * *An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents*
			Indicator 5, device registry completion: ≥ 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
		Focus Area 5: Stroke services	Indicator 1 ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2, thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3, inpatient rehabilitation: 80% patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4, community rehabilitation: 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
SS15	Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive or are waiting for their procedure 14 calendar days or less; 100% within 30 days or less	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive or are waiting for their procedure in 42 calendar days or less; 100% within 90 days or less	
		70% of people waiting for a surveillance colonoscopy receive or are waiting for their procedure in 84 calendar days or less of the planned date; 100% within 120 days or less	
		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	
SS16	Delivery of collective improvement plan	TBC	
SS17	Delivery of Whānau ora	Provide reports as specified	
Better population health outcomes supported by primary health care			
PHO1	Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PHO2	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified	
PHO3	Access to care (PHO enrolments)	Meet and/or maintain the national average enrolment rate of 90%	
PHO4	Better help for smokers to quit in primary care	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual Plan			
Annual plan actions – status update reports		Provide reports as specified	

Part B
Statement of Intent

Incorporating

Statement of Performance Expectations

and

Financial Performance

1 Overview of Strategic Priorities

1.1 Strategic intentions and priorities

Vision and mission

Northland DHB's vision: "A Healthier Northland / He Hauora Mo Te Tai Tokerau"

Northland DHB's mission: Achieved by working together in partnership under the Treaty of Waitangi to:

- improve population health and reduce inequities
- improve the patient experience
- live within our means.

Mahi tahi te kaupapa o Te Tiriti o Waitangi he whakarapopoto nga whakaaro o te Whare Tapa Wha me te whakatuturutahi i te tino rangatiratanga te iwi whanui o Te Tai Tokerau.

Northland DHB is developing a strategy that will provide guidance for our own plans as well as those of the rest of the Northland health sector. Embedded within this will be a population health outcomes approach, with outcome statements and high-level measures.

Strategic priorities

A summary of the presentation made to the Ministry of Health on 8 May 2019.

Northland's characteristics	Areas of strong performance	What we are doing in 2019/20
Poverty	Health Targets for smoking maternity, RHK	Contain cost growth
Population growth	Hospital-acquired and healthcare-associated infections	Seamless system
Ageing population	↓ Relative Stay Index	Shift resources upstream
Rurality	SAFER patient flow	Mental health initiatives
High road fatalities	↓ meth demand (with Police)	Ageing in place
High suicide rate	Pregnancy & parenting service	Cross-sectoral collaboration
Challenges	Primary mental health national collaboration	Staff wellbeing
Inequities for Māori	Cross-sectoral work	Strong Board-Iwi relationship
Long term conditions	Suicide prevention	↑ community involvement
Primary capacity and access	Māori community engagement	Stewardship (VfM, QI)
Ageing workforce	Telehealth & mobility	Staff health, safety, wellbeing
Recruitment	CRAB, HRT benchmarking	Population Health Indicators Framework
% Māori workforce	Innovation, Excellence & Improvement Programme	
↑ demand ED, medical	Stewardship (VfM, QI)	
Age of facilities	Clinical governance	
Vaccination rates	Workforce measures	
	Māori training	
	Regional work	
	Neighbourhood Healthcare Homes	
	Health & Social Care Coordination	
	Primary care collaboration → Mahitahi Hauora	
	Integrated Operations Centre	

Commitments

DHBs have a statutory responsibility under the *Treaty of Waitangi* to put into practice its principles of partnership, protection and participation. NDHB is acutely conscious that Māori, who comprise about a third of our population, suffer most from health and other inequities and we are committed to upholding the three Treaty principles.

Northland DHB is committed to the *New Zealand Health Strategy* and its five themes of people powered, closer to home, value and high performance, one team, and smart system.

Northland DHB is also committed to *He Korowai Oranga* Māori Health Strategy that sets the overarching framework to guide the Government and the health and disability sector to achieve the best outcomes for Māori.

Among DHBs, Northland has one of the highest percentages of older people in our population (in 2018, 19.6% compared with 15.2% nationally) and it is also ageing faster that most other DHBs (by 2028, 25.7% compared with 19.4% nationally). Northland DHB is committed to the *Healthy Ageing Strategy* and its vision that older people live well, age well and have a respectful end of life in age-friendly communities.

Northland DHB is committed to the *UN Convention on the Rights of Persons with Disabilities*, whose purpose is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The New Zealand *Disability Strategy 2016-2026*) also forms part of Northland DHB's disability strategic framework, with service improvements for 2019/20 focussing on accessibility, attitudes, health and wellbeing, and leadership.

Northland DHB is committed to the principles of *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018*, namely:

- respecting Pacific culture
- valuing family and communities
- quality health care
- working together – integration.

2 Managing our Business

2.1 Organisational performance management

Northland DHB has clear lines of accountability for reporting and monitoring that are captured in position descriptions. Reports on management performance are provided monthly, quarterly and annually and presented at various venues including the Board, ELT, Clinical Governance, Medical ELT, and the Organisational Management Group.

Northland DHB has an ELT dashboard that is continually being improved and refreshed.

Processes for specific areas of operation are described in more detail in 4.1.2 to 4.1.6.

2.2 Funding and financial management

Northland DHB's finances are thoroughly monitored both internally and by external agencies.

Internally:

- our financial management systems enable us to set targets and monitor performance on finance, workforce and service delivery
- monthly Internal Planning, Performance Monitoring and Reporting meetings monitor finance and other performance based on the targets set above

- financial reports and reviews occur at the Board's Audit and Risk Committee, and at Board meetings
- delegated authorities are reviewed annually and approved by the Board.

Externally:
- MoH monitors our financial performance through the reports we send them monthly
- once a year Audit NZ audits our financial statements and our Annual Report
- the regional internal audit service audits and monitors our financial systems and performance, as well as those of the Northern Region's shared service agency healthAlliance
- healthAlliance provides regional oversight of information systems and technology, and NZ Health Partnerships was established nationally to save money by reducing administrative, support and procurement costs.

Our infrastructure, clinical equipment and information systems investment portfolios are each governed by a steering group comprising clinical staff, consumer representatives and management. NDHB is currently in the process of embedding the P3M3 framework to support our programme management.

2.3 Investment and asset management

Northland DHB is a Tier 2 Intensive Investment Agency under Treasury's Investment Management and Asset Performance (IMAP) with a Cabinet-approved Investor Confidence Rating of 'C' based on the assessment undertaken in 2016. The rating reflects Northland DHB's ability to manage investment portfolios and to successfully deliver promised benefits in the medium and long term. A review of The Northern Regional Health Plan with a focus on primary and secondary integration is currently underway to update this document with approved strategic goals aligning to Ministry of Health priorities, NZ Health Strategy, Northland DHB planning documentation and the Long Term Investment Plan. Northland's long term intentions include the redevelopment of the Whangārei Hospital campus and an electronic health record covering primary and secondary services.

A second Treasury lead Investor Confidence Rating assessment is underway in the first half of 2019 which will include a complete review and update to Asset Management Plans, Polices, Strategy and the Long Term Investment Plan.

2.4 Shared service arrangements and ownership interests

The Northland DHB group consists of the parent, Northland DHB, and Kaipara Joint Venture Trust (51% ownership by Northland DHB). Northland DHB has a joint venture with the other Northern Region DHBs in healthAlliance NZ Limited (25%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

2.5 Risk management

Northland DHB manages its risk through a Risk Committee that provides oversight and management of all risks. The Risk Committee provides an in-depth appraisal and management of corporate risks each month, and prepares a report to the Operational Management Group that provides governance of risk. The Risk Committee delivers monthly reports to the Finance, Risk and Audit Committee. The Emergency and Corporate Risk Manager attends these meetings and provides any updates and clarifications that may be needed for the Board members.

The governance of risk is managed in the following way:
- a clear risk policy that all staff are made aware of
- a guide for staff on how to appropriately identify and manage risks
- monthly review of the high to extreme risks in Datix
- a monthly Risk Committee meeting to review the top risks and identify management plans where necessary
- monthly reporting to the Operational Management Group

- monthly reporting to the Finance, Risk and Audit Committee.

2.6 Quality assurance and improvement

Our commitment to quality and safety aligns with the national vision and includes:

- six-weekly quality reports produced for the Board's Hospital Advisory Committee, the Patient Safety Committee and the Clinical Governance Board
- monitoring clinical risk, adverse events and errors, complaints, benchmarking with other DHBs, improvements to clinical systems
- a dedicated clinical audit position that is supported by the Clinical Audit Committee
- robust documents control process to ensure high quality of policies, procedures, processes and patient information
- an electronic risk register so all parts of the organisation can record and manage risk
- a Patient Safety and Quality Improvement framework, a commitment to our patients/clients, staff and community to improve quality through focused targets and actions.
- coordination of and support for the Consumer Council
- monitoring and driving improvement for established national quality safety markers
- incorporation of equity in all we do.

2.7 Partnership with Public Health

Northland DHB will work in partnership with our public health unit in their work on promoting and protecting population and environmental health, delivering services that improve the effectiveness of prevention activities in other parts of the health system, cross-sectorally, and in undertaking regulatory functions.

3 Statement of Performance Expectations

The Statement of Performance Expectations (SPE) tells our 'performance story', what we produce (outputs) and what we aim to achieve for Northlanders (impacts) and our society (outcomes). The SPE is required under the Crown Entities Act 2004 to enable the Office of the Auditor General to monitor Northland DHB's performance. The SPE together with modules 1, 3 and 4 of the Annual Plan comprises our Statement of Intent

The SPE concentrates on cornerstone measures that represent the wide range of services for which Northland DHB is responsible. There is considerable overlap between the SPE's measures and those in section 2 of the Annual Plan; the latter is prepared in response to a list of specific Ministry of Health-led national priorities, while the SPE takes a higher level, more strategic view.

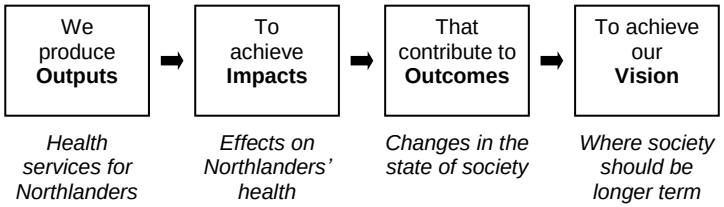
Output classes

Services are grouped into four output classes:

Prevention	Publicly funded services that protect and promote health across the whole population or particular sub-groups of it. These services improve the health status of the population, as distinct from curative and rehabilitative services (the other three output classes) which repair or support illness or injury.
Early detection and management	Commonly referred to as 'primary' and/or 'community' services, these can be accessed directly by people in the community. They are delivered by a range of providers including general practice, Māori health providers, pharmacies, and oral health services. The services are generalist (non-specialist) in nature, and similar types of services are delivered in numerous locations across the community.
Intensive assessment and treatment	Complex services provided by those who work in a particular specialty, commonly referred to as 'secondary' or 'hospital' services. They include emergency department, inpatient, outpatient, daypatient, and diagnostic services. They are accessible only by referral from a primary health practitioner and available in few locations.
Rehabilitation and support	Services for older people (home and community support services, residential care and services for dementia) and palliative care services.

Intervention logic

The Statement of Performance Expectations is structured according to the following intervention logic.



Impacts contribute to Outcomes, and together they contribute to High-level Outcomes (measured by High-level Measures). For example, higher rates of cessation among smokers and immunisation among children create a healthier population. Screening for cancers, cardiovascular disease and diabetes prevent illness and disease or identify conditions at early stages so they can be monitored and treated more effectively. Ongoing monitoring and support of people with long term mental health conditions help maintain their stability. Home and community support services help older people remain independent in the community, and residential care services offer the best quality of life for those no longer able to manage on their own. Quality services that are clinically and culturally safe, and provided in a timely manner encourage people to attend and be involved in their care, and that means better health status.

Through the measures described above and in the diagram on the next page, the SPE addresses the Triple Aims of population health, patient experience and value and sustainability.

Wherever possible, Impacts are measured by Māori and non-Māori so we can monitor inequities and reduce these over time.

Summary of Statement of Performance Expectations 2019/20

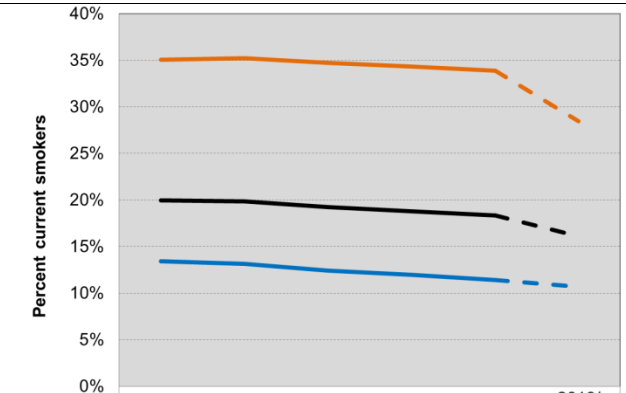
All measures by Māori and non-Māori where data is available.

Vision	A healthier Northland									
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities		Patient experience: patients and whānau experience clinically and culturally safe, good quality, effective, efficient and timely care			Value and sustainability: the Northland health system lives within available funding by improving productivity and prioritising resources to their most cost-effective uses				
High-level Measures	Life expectancy gap between Māori and non-Māori ↓ by 2 years	↓ gaps between: (a) Māori and non-Māori; (b) Northland and NZ	↓ mortality rate (age-standardised)	↓ infant mortality	Unplanned hospital admissions for Northlanders are reduced by 2,000 by 2017			>95% of patients report they would recommend the service provided		
Outcomes	Healthy population	Prevention of illness and disease	Reversal of acute conditions		Optimum quality of life for those with long term conditions			Independence for those with impairments or disability support needs		
Impacts	**Smoking cessation** Lower prevalence of smoking-related conditions	**Healthy children** Children are healthy from birth and have a healthy foundation for adulthood	**Effective primary care** People manage in the community through effective primary care services	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	**Mental disorders** Acute episodes are minimised, clients achieve greater stability, and quality of life is improved for both clients and their families	**Elective surgery** Fewer debilitating conditions, delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	% of adults who are current smokers % of pregnant women who identify as smokers on registration with a midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Full and exclusive breastfeeding at 3 months % of 8-month-olds who have their primary course of immunisation on time Average number of decayed, missing or filled teeth in Y8 students % of 4-year-olds identified as obese in B4 School Checks will be offered a referral to a health professional	Ambulatory sensitive hospitalisation rate/100,000, unstandardised	% of diabetics receiving annual free checks who have good blood sugar management % eligible people receiving cardiovascular risk assessment in the last 5 years	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations % of patients who receive first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks	% of people with enduring mental illness aged 20-64 who are seen over a year	Increase in elective surgical discharges	% of patients admitted, discharged or transferred from and ED within 6 hours	Number of in hospital falls causing fracture of neck of femur per month Percentage of opportunities for hand hygiene taken Surgical site infections per 100 hip and knee procedures Patient deterioration	Home and Community Support Services (HCSS) clients assessed using interRAI tool HCSS providers certified ARRC providers with at least 3 years certification
Output Classes	**Prevention**		**Early detection and management**		**Intensive assessment and treatment**			**Rehabilitation and support**		
Outputs	Advice and help offered to smokers in primary care Advice and help offered to pregnant women Advice and help offered to smokers in hospital	Midwifery services by LMCs MIdwifery services by DHB Support by lactation consultants Oral health assessment and treatment Immunisations in primary care 4-year-olds given B4SC	Services provided in primary care Acute hospital services	Assessment, diagnosis and treatment in primary care	Screening for breast cancer Screening for cervical cancer Cancer risk assessments in primary care Provision of cancer treatment	Specialised clinical support by NDHB community mental health services Admission to hospital for those with acute mental illness	Elective surgical procedures	Assessments, treatments performed in EDs	Leadership, advice and monitoring by Quality Improvement Directorate Effective clinical services Patient pathways, hospital discharge processes	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	People attending primary care who have ever smoked	Hospital births Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care B4SC performed	Acute hospital discharges	Risk assessments and monitoring of people with diabetes and/or CVD	Screening for breast and cervical cancer Referrals for radiotherapy and chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Increase in the volume of elective surgery	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

Output Class 1: Prevention

Impact: Lower prevalence of smoking-related conditions.

Measure: % of adults who are current smokers



	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20 target
Total	20.0%	19.9%	19.3%	18.8%	18.3%	16.1%
Maori	35.1%	35.2%	34.7%	34.4%	33.9%	28.5%
Non-Maori	13.4%	13.1%	12.4%	11.9%	11.4%	10.7%

Measure type: Coverage

Rationale

Smoking and obesity are the two most significant drivers of long term conditions.

Currently, according to data from the Northland PHOs, 33.9% of Māori and 11.4% of non-Māori smoke.

New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.

The dotted lines in the graph reflect the percentage drops required in 2019/20 to make straight-line progress towards reaching the 2025 target. Non-Māori smoking rates are reducing at the desired rate, but Māori smoking rates need to decline faster.

Note that this is not the Health Target, which looks only at those given brief advice to quit. The proportion of the population who smoke (extracted from PHO data) is a more relevant measure in the context of the SPE.

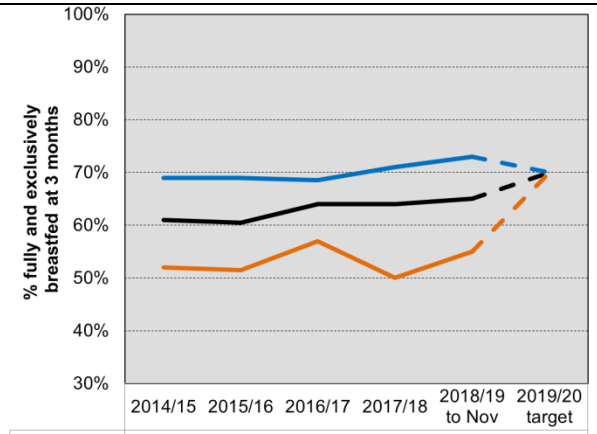
Outputs

Primary care records show 114,508 Northlanders who have ever smoked, of whom 24,039 are current smokers (2018/19 Q3).

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: Full and exclusive breastfeeding at 3 months

Measure type: Coverage



	2014/15	2015/16	2016/17	2017/18	2018/19 to Nov	2019/20 target
Total	61%	61%	64%	64%	65%	70%
Maori	52%	52%	57%	50%	55%	70%
Non-Maori	69%	69%	69%	71%	73%	70%

Rationale

Higher rates of breastfeeding in infancy correlate with a lower chance later in life of developing health problems, including long term conditions.

Breastfeeding rates are lower among Māori.

A higher percentage of the child population is Māori, so improving infant health will have a significant effect on improving the health of Māori over time.

Outputs

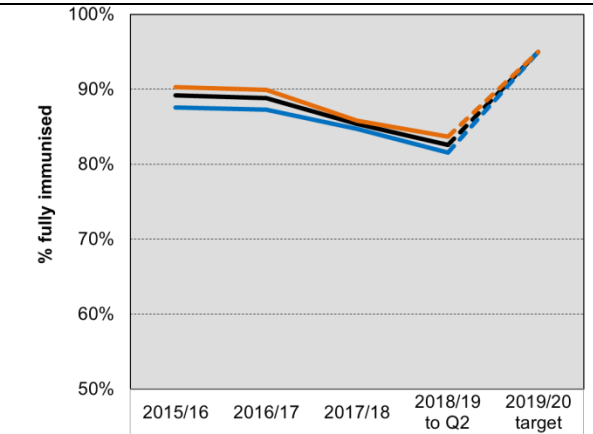
Total NDHB hospital births: 1,966 for the twelve months ending March 2018.

887lactation consultant patient contacts for the twelve months ending March 2018.

Mothers are provided with education and support to encourage them to breastfeed, whether they are supported by an independent midwife (home and hospital births) or NDHB midwife (hospital births).

Measure: % of 8-month-olds who have their primary course of immunisation on time

Measure type: Coverage



	2015/16	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	89.2%	88.8%	85.3%	82.6%	95.0%
Non-Maori	87.6%	87.3%	84.7%	81.5%	95.0%
Maori	90.3%	89.9%	85.8%	83.6%	95.0%

Rationale

Improved immunisation coverage leads directly to reduced rates of vaccine-preventable (communicable) disease, and that means better health and independence for children and longer and healthier lives.

Immunisations are one of the most cost-effective ways of improving health.

Northland has one of the highest rates of any DHB for parents declining to have their child immunised or opting off the National Immunisation Register. Encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage. The High Five Project as part of the First 2000 Days Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.

Outputs

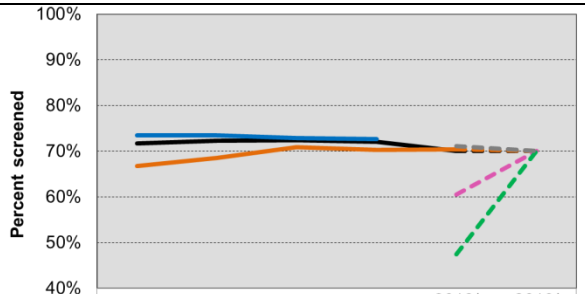
1,893 children were fully immunised before 8 months of age during the twelve months ending March 2019.

NDHB works with primary care providers to continue to improve the rate and timeliness of immunisation.

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: Breast cancer screening in eligible (aged 50-69) populations

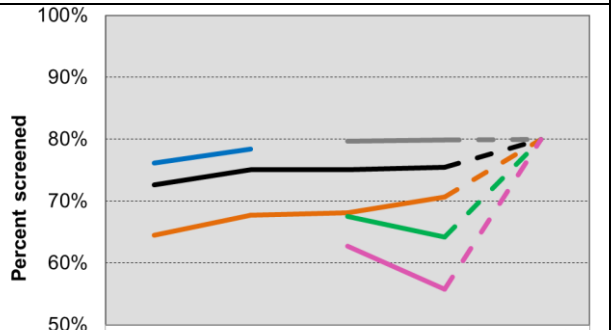
Measure type: Coverage



	2014/15	2015/16	2016/17	2017/18	2018/19 to Sep	2019/20 target
Total	71.7%	72.3%	72.4%	72.0%	70.0%	70.0%
Maori	66.7%	68.5%	70.9%	70.3%	70.4%	70.0%
Pacific					60.5%	70.0%
Asian					47.4%	70.0%
Other					71.1%	70.0%
Non-Maori	73.5%	73.5%	72.9%	72.6%		70.0%

Measure: Cervical cancer screening in eligible (aged 25-69) populations

Measure type: Coverage



	2015/16	2016/17	2017/18	2018/19 to Sep	2019/20 target
Total	72.6%	75.1%	75.1%	75.5%	80.0%
Maori	64.5%	67.7%	68.1%	70.7%	80.0%
Pacific			67.6%	64.2%	80.0%
Asian			62.7%	55.8%	80.0%
Other			79.6%	79.9%	80.0%
Non-Maori	76.2%	78.3%			80.0%

Rationale

Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. The only two formal screening programmes that exist in New Zealand are for breast cancer and cervical cancer.

Multiple lines for ethnicity exist in both graphs because in 2018/19 Q1 the National Screening Unit replaced the old 'other' category with finer divisions of Pacific, Asian and other.

Outputs

9,289 eligible women were screened in year to March 2019, including 2,504 Māori and 6,785 non-Māori.

Outputs

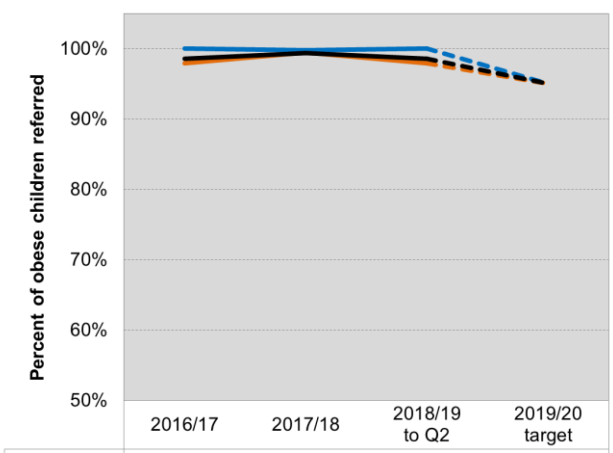
32,326 eligible women screened in the three years up to March 2019, of whom 9,810 were Māori and 23,416 were non-Māori.

Output Class 2: Early Detection and Management

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure: % of 4-year-olds identified as obese in B4 School Checks who are offered a referral to a health professional

Measure type: Coverage



	2016/17	2017/18	2018/19 to Q2	2019/20 target
Maori	98%	99%	98%	95%
Non-Maori	100%	100%	100%	95%
Total	99%	99%	99%	95%

Rationale

Obesity, along with smoking, is the most significant driver of long term conditions.

In Northland, 50% of Māori are obese compared with 28% of non-Māori (2011-14 NZ Health Survey).

This measure is part of the national plan to reduce obesity, which has three prongs:

- targeted interventions for those who are obese
- increased support for those at risk of becoming obese
- broad approaches to make healthier choices easier for all New Zealanders.

Other initiatives in Northland include:

- the Food Rescue Project. which redistributes food from suppliers across the community
- the Kai Ora Fund, which enables Northlanders to grow and eat nutritious and sustainably grown local food
- promotion of Healthy Kai policies across government and non-government organisations
- the promotion of water-only policies in schools.

Outputs

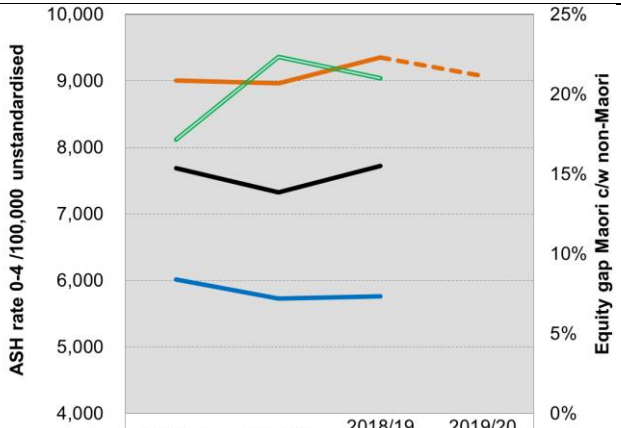
1,9814-year-olds checked Mar 2018-Feb 2019

Impact: People manage in the community through effective primary care services

Measure

Ambulatory sensitive hospitalisation rate per 100,000 ages 0-4, unstandardised

Measure type
Quality



	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	7,690	7,329	7,728	
Maori	9,011	8,966	9,352	9,072
Non-Maori, non-Pac	6,019	5,729	5,767	
Equity gap	17%	22%	21%	

Rationale

Ambulatory sensitive hospitalisations (ASH) are potentially avoidable if patients had accessed primary care services, their conditions were diagnosed, then either cured or managed well.

Lower rates of ASH mean people have their conditions treated earlier and more effectively. ASH admissions form a substantial proportion of hospitalisations and affect Māori inequitably.

Lowering ASH rates will free up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar. Achieving this involves managing the complex interface between primary and secondary care, for which NDHB has a number of initiatives in place or planned. For example, NDHB is trialling a Primary Options Acute Demand Management Service to enable GPs to flexibly develop management plans for their patients and thus avoid hospital admissions.

The 2019/20 target is based on the SLM plan's target of "reduce the number of tamariki Māori aged 0-4 years ASH conditions by 3%". The plan contains no targets for other ethnic groups.

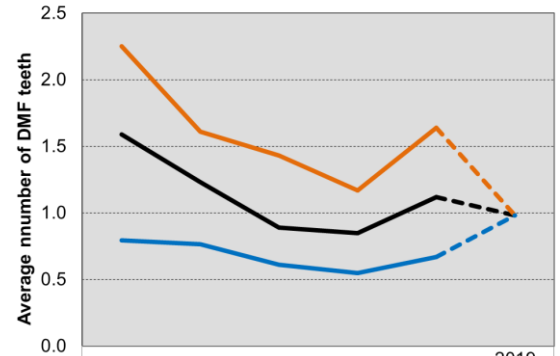
Outputs

Total ASH discharges ages 0-4 2018 CY 910.

Impact: Children are healthy from birth and have a healthy foundation for adulthood

Measure:
Average number of decayed, missing or filled teeth in Y8 students

Measure type:



	2014	2015	2016	2017	2018	2019 target
Total	1.59	1.23	0.89	0.85	1.12	0.98
Maori	2.25	1.61	1.43	1.17	1.64	0.98
Non-Maori	0.80	0.76	0.61	0.55	0.67	0.98

Rationale

Oral health is about more than just the state of teeth and gums, because the effects of poor oral health can be wide-ranging and lifelong. Significant rates of disease create pain and discomfort, limit what children can eat, and affect self-image and confidence.

For many years Northland had among the worst oral health statistics for children, though significant improvements have been made in the last few years.

Northland will always struggle to reach the oral health status of DHBs that have fluoridated water supplies. Northland remains unfluoridated (a brief foray into reticulated fluoridation in two Far North communities was abandoned in 2009).

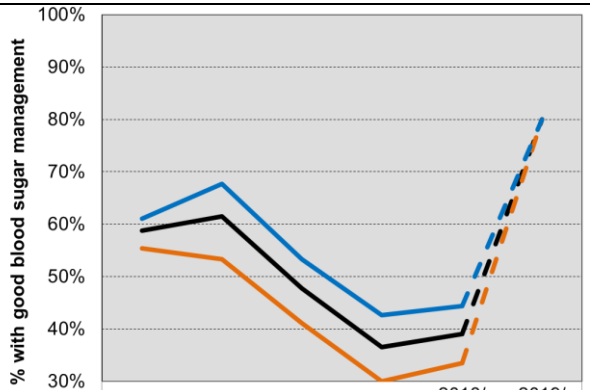
Outputs

1,852 Year 8 students were treated by NDHB's services in the 2018 calendar year.

Impact: Amelioration of long term condition disease symptoms and/or delay in their onset

Measure: % of diabetics who receive annual free checks who have good blood sugar management

Measure type:
Coverage



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	58.8%	61.5%	47.8%	36.5%	39.0%	80.0%
Maori	55.4%	53.3%	41.2%	30.0%	33.5%	80.0%
Non-Maori	61.1%	67.8%	53.3%	42.6%	44.4%	80.0%

Rationale

Diabetes is an increasingly common long term condition. It is a major cause of illness and a significant contributor to cardiovascular disease.

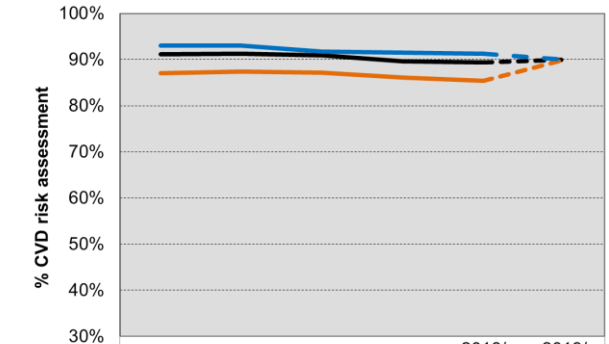
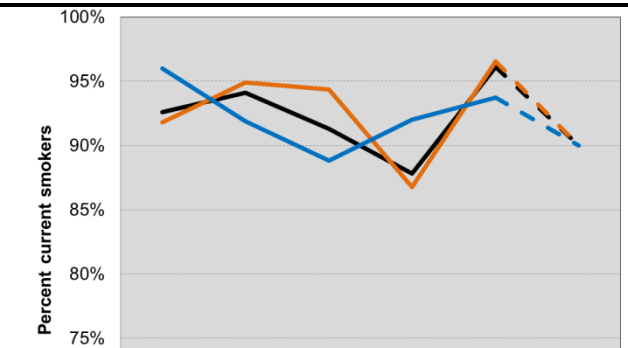
It is strongly associated with excess weight, which affects a disproportionate number of Northlanders, especially Māori. Prevalence increases with age, so prompt action is imperative in the face of the ageing population.

Although incurable, the effect of diabetes on daily life can be minimised through early detection, regular (annual) checks, good clinical management and a healthy lifestyle.

Accurately monitoring progress on this measure is difficult because over the last few years the Ministry has changed the criteria for the denominator several times.

Outputs

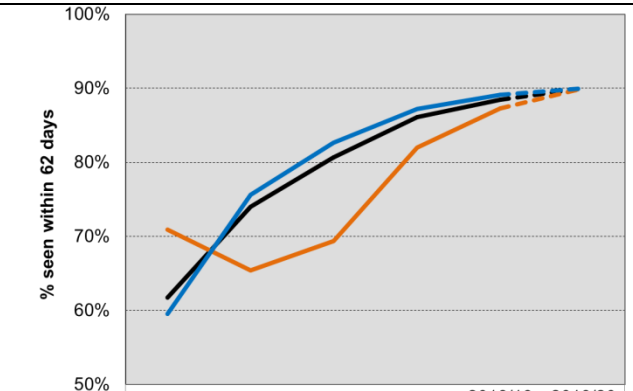
As at Dec 2018, 9,621 people are on the Northland diabetes register, of whom 4,152 are Māori and 5,469 are non-Māori.

Measure: Eligible people receiving cardio-vascular (CVD) risk assessment in the last 5 years **Measure type:** Coverage	 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 to Q2 | 2019/20 target Total: 91.2% | 91.3% | 90.9% | 89.7% | 89.4% | 90.0% Maori: 87.0% | 87.4% | 87.1% | 86.0% | 85.4% | 90.0% Non-Maori: 93.0% | 93.0% | 91.8% | 91.5% | 91.2% | 90.0%	**Rationale** Along with cancer, cardiovascular (heart and circulatory) disease is the most common long term condition. Prevalence of CVD conditions is higher among Māori. It also increases with age, so the ageing population means we need to carefully monitor and control the incidence and severity of conditions. Regular screening identifies those at risk of developing cardiovascular disease, and its onset can be prevented or delayed by lifestyle and clinical interventions. Regular screening also helps earlier identification of those who already have the condition.	**Outputs** 53,929 CVD risk assessments performed in primary care over the five years to March 2019, of whom 17,050 were Māori, Pacific or Indian (the latter are a high-risk group for heart disease) and 36,879 were other ethnicities.
Measure: % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking **Measure type:** Coverage	 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 to Q2 | 2019/20 target Total: 92.6% | 94.1% | 91.3% | 87.8% | 96.1% | 90.0% Maori: 91.8% | 94.9% | 94.4% | 86.8% | 96.5% | 90.0% Non-Maori: 96.0% | 91.9% | 88.8% | 92.0% | 93.8% | 90.0%	**Rationale** Smoking and obesity are the two most significant drivers of long term conditions. Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.	**Outputs** Total NDHB hospital births: 1,966 for the twelve months ending March 2018.

Output Class 3: Intensive Assessment and Treatment

Impact: If curable, increased likelihood of survival; if incurable, reduced severity of symptoms

Measure: % of patients who receive first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	61.7%	74.0%	80.7%	86.1%	88.5%	90.0%
Maori	70.9%	65.4%	69.4%	82.0%	87.3%	90.0%
Non-Maori	59.5%	75.6%	82.7%	87.2%	89.1%	90.0%

Measure type:
Coverage

Rationale

Along with cardiovascular disease, cancers are the most common type of long term condition.

Some of the biggest gains are to be made by ensuring early access to cancer treatment to improve the chances of recovery and to alleviate symptoms.

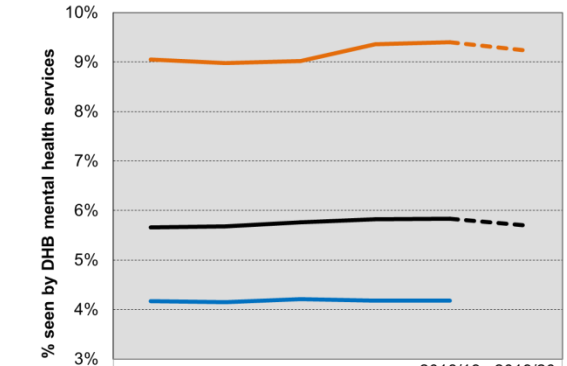
Outputs

588 patients referred urgently with high suspicion of cancer for the twelve months ending March 2019 who commenced first treatment.

Impact: Acute episodes are minimised, clients achieve greater stability, and quality of life is improved for both clients and their families

Measure: % of people with enduring mental illness aged 20-64 who are seen over a year

Measure type: Coverage



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	5.66%	5.68%	5.76%	5.83%	5.83%	5.70%
Maori	9.06%	8.98%	9.02%	9.36%	9.40%	9.24%
Non-Maori	4.17%	4.15%	4.22%	4.18%	4.18%	

Rationale

Severe mental disorders permanently affect 3% of the population.

Mild to moderate disorders affect 20% of the population at any one time and 90% over a lifetime.

Mental health is a priority for the health sector; the guiding document is *Rising to the Challenge*, the national mental health and addictions strategy 2012-2017.

MoH does not require DHBs to report on non-Māori, nor set a target for them.

Outputs

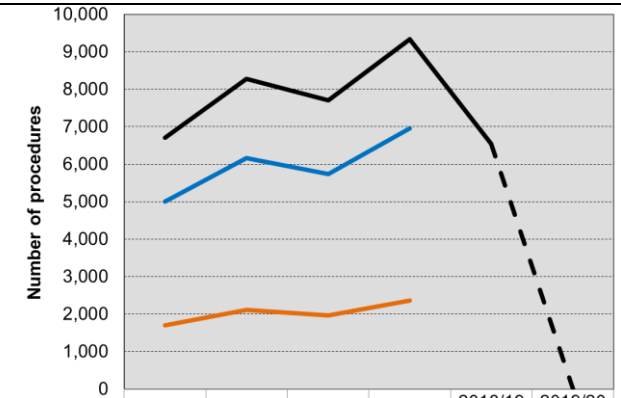
Number of contacts by community mental health services with people who have enduring mental illness (2018/19 extrapolated from 9 months data):

Direct (with client and/or whānau)	92,250
Care coordination (on behalf of client, with another agency)	19,000

Impact: Fewer debilitating conditions and delayed onset of long term conditions

Measure: Increase in elective surgical discharges

Measure type: Coverage



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q3	2019/20 target
Total	6,704	8,275	7,707	9,328	6,545	0
Maori	1,702	2,110	1,965	2,366		0
Non-Maori	5,002	6,165	5,742	6,962		0

Rationale

Elective surgery is an effective way of increasing people's functioning because it remedies or improves conditions that restrict functioning. Timely access is considered by the Ministry of Health to be a measure of the effectiveness of the health system.

Increasing the number of operations will improve access and reduce waiting times, as well as increase public confidence that the health system is meeting their needs.

MoH focuses only on data for total patients, hence only one target line in the graph.

Outputs

Target planned elective surgical discharges 2018/19 is 9,146. To the end of May 2019, 26.9% of patients were Māori and 73.1% were non-Māori.

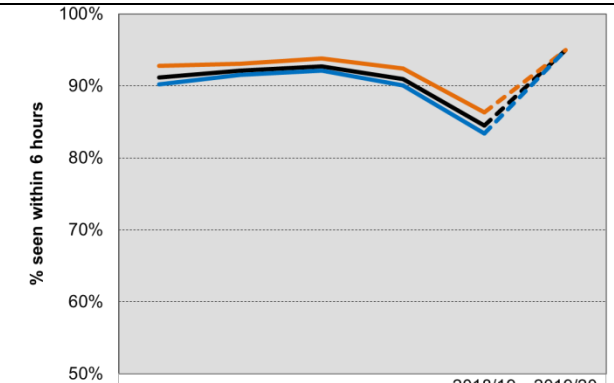
The data used here represents the targets set in each year's Annual Plan. These numbers do not represent total extra elective surgical discharges because every year MoH provides more funding for more procedures, and those amounts cannot be predicted. The most rational way of assessing NDHB's performance is against the targets agreed before the year starts.

Note: targets for 2018/19 are provisional.

Impact: More timely assessment, referral and treatment

Measure: 95% of patients will be admitted, discharged or transferred from and ED within 6 hours

Measure type: Timeliness



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q2	2019/20 target
Total	91.2%	92.2%	92.7%	90.9%	84.5%	95.0%
Maori	92.8%	93.1%	93.8%	92.4%	86.4%	95.0%
Non-Maori	90.2%	91.6%	92.1%	90.1%	83.4%	95.0%

Rationale

Length of stay in ED is an important measure of the quality of acute (emergency and urgent) care in our public hospitals, because:

- EDs are designed to provide urgent health care; so time spent waiting and the timeliness of treatment are by definition important for patients
- long stays and overcrowding in EDs are linked to negative clinical outcomes for patients such as increased mortality and longer inpatient length of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients.

Outputs

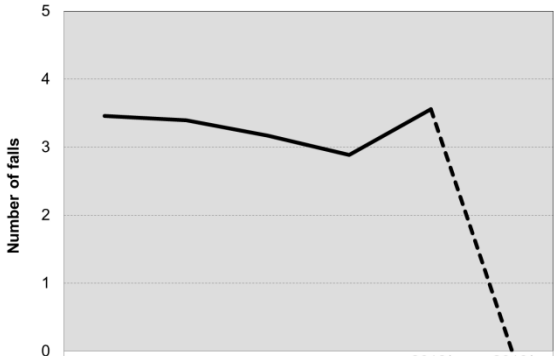
Emergency services provided by EDs at Whangārei Hospital, NDHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

Emergency department attendances for the year ended 2018/19 Q3 45,433.

Impact: Fewer adverse clinical events. **Measures type:** Quality

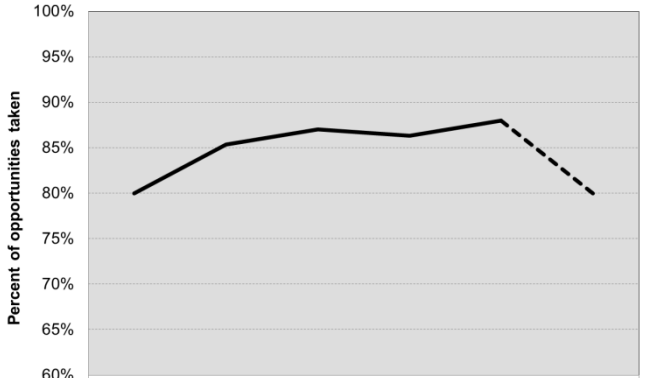
Number of in hospital falls causing fracture neck of femur per month

Target is ideally zero. Though this is achieved in most months, it is unrealistic to expect it to be achieved every month.



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q3	2019/20 target
Number of in-hospital falls causing fracture of neck of femur	3	3	3	3	4	0

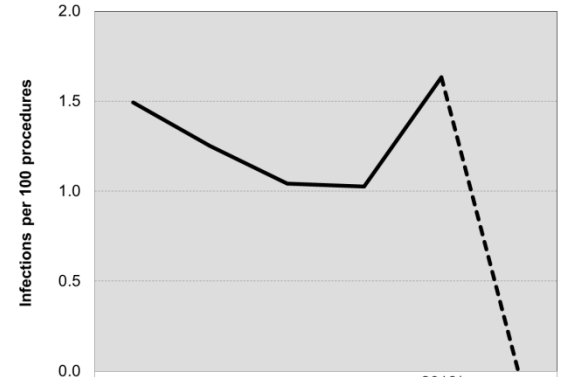
Percentage of opportunities for hand hygiene taken



	2014/15	2015/16	2016/17	2017/18	2018/19 to Q1	2019/20 target
% of hand hygiene opportunities taken	80.0%	85.3%	87.0%	86.3%	88.0%	80.0%

Surgical site infections per 100 hip and knee procedures

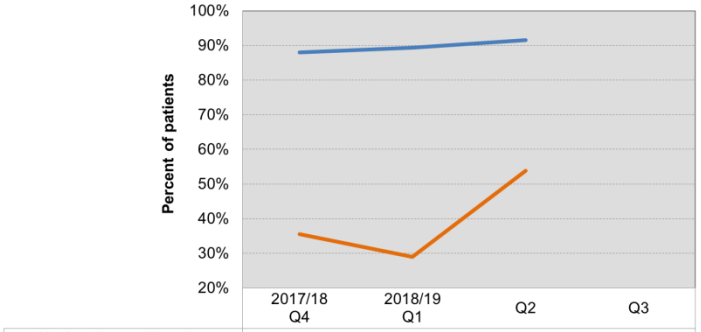
Target is ideally zero. Though this is achieved in many months, it is unrealistic to expect it to be achieved every month.



	2014/15	2015/16	2016/17	2017/18	2018/19 to Sep	2019/20 target
Surgical site infections per 100 hip and knee procedures	1.5	1.3	1.0	1.0	1.6	0

Patient deterioration

New measure from April 2018 so data is presented by quarter. A national target has not yet been set.



	2017/18 Q4	2018/19 Q1	Q2	Q3
% of patients with early warning scores calculated correctly	87.9%	89.3%	91.6%	
% of patients who triggered an escalation of care and received the appropriate response	35.6%	28.9%	53.9%	

Rationale

Patient safety can only be managed if outcomes are measured and monitored, and improvement plans put in place.

The Health Quality and Safety Commission has developed nationally consistent Quality and Safety Markers. The data is from: https://public.tableau.com/profile/hqi2803#!/vizhome/QSMlocalreportMarch2019draft/Homepage .

Outputs

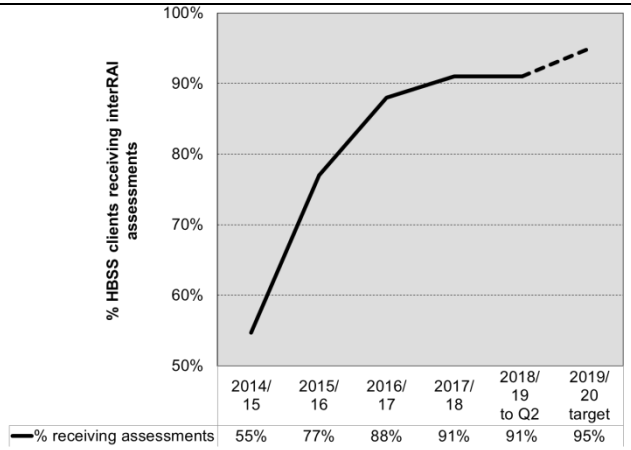
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

Output Class 4: Rehabilitation and Support

Impact: Older people requiring support or care receive services appropriate to their needs.

Measure: % Home and Community Support Services (HCSS) clients assessed using interRAI tool

Measure type: Coverage



Rationale

Older people who remain in the community with the assistance of home and community support services are more able to 'age in place' (that is, their lifestyle and supports are more appropriate to their needs, and they live safely and independently in the community). The more that happens, the less pressure there will be on hospital and aged residential care resources. Good quality clinical assessment for older people who live at home contributes to achieving these aims.

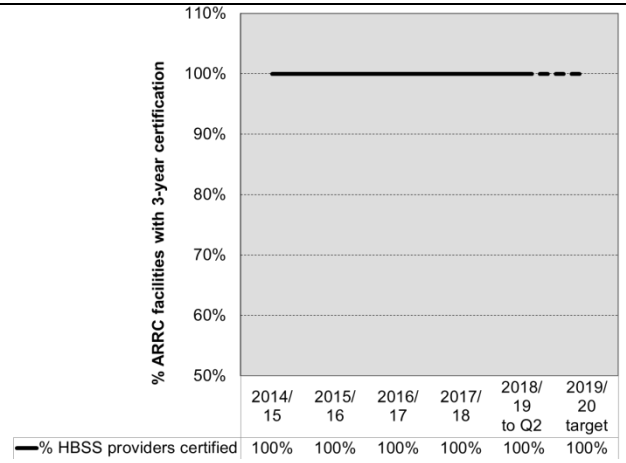
interRAI is collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled. InterRAI has developed assessment instruments for a range of populations in various areas of health care, including home care and long term care facilities.

Outputs

1,972 clients who receive long term home based support services have ever been assessed using the interRAI Home Care or Contact Assessment tool as at Dec 2018.

Measure: % of HCSS providers certified

Measure type: Quality



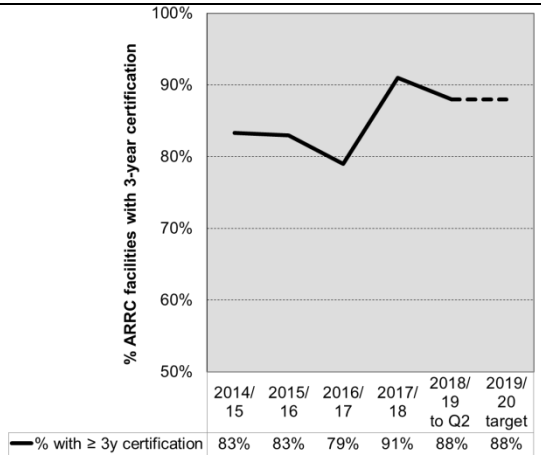
Rationale

Certification against the Home and Community Support Sector Standard (NZS 8158:2012) is aimed at ensuring people receive good quality support in their homes. The standard sets out what people receiving home and community support services can expect and the minimum requirements to be attained by organisations.

All NDHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2,668 people in the community up to Dec 2018.

Measure: % of ARRC providers with at least 3-year certification **Measure type:** Quality		**Rationale** Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards. The period of certification for aged residential care providers reflects their risk level; the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.	**Outputs** Since 2010 a single audit process has encompassed DHB aged care contracts and MoH certification audits. DHBs on work with providers on corrective action plans to address any matters identified though the audits, monitor progress against the agreed corrective action plans, and manage risks that may arise. In 2018/19 there are 24 facilities, of which 15 have 3-year certification and 7 have 4-year; 22/24 = 92%.

4 Financial performance

The forecast financial statements for the period 2019/20 to 2022/23 included in this Statement of Performance Expectations were authorised for issue by the Board on 28 June 2019.

The forecast financial statements were prepared on the basis of the key assumptions for the financial statements and the significant accounting policies. 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 2019/20 and out-year budgets are still to be approved by the Minister of Health.

Key Assumptions for Financial Statements

Revenue Growth

The majority of Northland DHB's revenue is from the Ministry of Health, made up mostly of population-based funding for the Northland DHB population and IDF revenue (for services delivered for other DHB's populations). The Ministry of Health advised us on 19 May of a PBFF funding increase of $26m.

Expenditure Growth

The underlying cost growth is driven by significant demographic growth pressure on services provided for the population, and direct expense increases including the cost of employment contract settlements (including step increases) staff FTE growth, inflationary pressure, infrastructure maintenance and contractual pricing on clinical and non-clinical supplies.

Capital Expenditure

Capital expenditure is for remediation of baseline infrastructure, upgrades, investment in new technology and clinical equipment replacement. Crown funding has been approved to finance major redevelopment and upgrade projects.

Statement of Comprehensive Income

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
DHB Provider Revenue	361,533	393,972	412,316	428,808	445,961	463,799
DHB Funder Revenue	272,492	291,270	299,749	311,739	324,208	337,177
DHB Governance & Administration	368	(0)	(0)	(0)	(0)	(0)
Inter District Flow Revenue	9,907	10,881	11,195	11,643	12,109	12,593
Total Revenue	644,300	696,123	723,260	752,190	782,278	813,569
DHB Provider Operating Expenditure	348,444	392,896	399,302	415,267	432,241	450,742
DHB Non Provider Funded Services	204,422	213,180	226,493	235,553	244,975	254,774
DHB Governance & Administration	325	347	583	606	630	656
Inter District Flow Expense	80,367	84,181	85,019	88,420	91,957	95,635
Total Operating Expenditure	633,559	690,604	711,397	739,846	769,802	801,806
Earnings before Interest, Depreciation, Abnormals & Capital Charge	10,742	5,519	11,863	12,344	12,475	11,763
Less						
Interest on Term Debt	71	126	469	487	507	527
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Earnings before Abnormals & Capital Charge	(2,322)	(8,637)	(3,669)	(3,809)	(4,324)	(5,708)
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	(2,322)	(8,637)	(3,669)	(3,809)	(4,324)	(5,708)
Capital Charge	8,465	9,282	9,131	9,503	9,520	8,690
Surplus (Deficit)	**(10,787)**	**(17,919)**	**(12,800)**	**(13,312)**	(13,844)	(14,398)
Revaluation of Fixed Assets	(20,602)	0	0	0	0	0
Comprehensive Income	**9,815**	**(17,919)**	**(12,800)**	**(13,312)**	**(13,844)**	**(14,398)**

Statement of Movements in Equity

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Equity at the beginning of the period	149,763	159,561	148,248	154,446	154,737	140,893
Surplus/Deficit for the period	(10,787)	(17,919)	(12,800)	(13,312)	(13,844)	(14,398)
Total Recognised Revenues and Expenses	138,976	141,641	135,448	141,135	140,893	126,495
Other Movements						
Revaluation of Fixed Assets	20,603	-	-	-	-	-
Other	(18)	7	- 2	2	-	-
Equity introduced (Repaid)	-	6,600	19,000	13,600	-	-
Equity at end of Period	**159,561**	**148,248**	**154,446**	**154,737**	**140,893**	**126,495**

Statement of Financial Position

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Equity						
Crown Equity	65,005	65,005	71,605	90,605	104,205	104,205
Retained Earnings	(8,396)	(26,315)	(39,116)	(52,427)	(66,271)	(80,670)
Subsidiaries & unrestricted trusts	208	215	215	215	215	215
Revaluation Reserve	102,743	102,744	102,744	102,744	102,744	102,744
Equity Injections	-	6,600	19,000	13,600	-	-
Total Equity	159,561	148,248	154,448	154,737	140,893	126,494
Represented by:						
Assets						
Current Assets	30,706	31,308	26,232	26,232	26,232	26,232
Non-Current Assets	227,087	234,545	253,864	263,068	258,047	253,895
Total Assets	257,792	265,854	280,095	289,300	284,278	280,127
Liabilities						
Current Liabilities	83,300	98,396	107,030	116,535	125,823	136,412
Non-Current Liabilities	14,931	19,210	18,618	18,029	17,564	17,221
Total Liabilities	98,231	117,606	125,648	134,564	143,386	153,633
Net Assets	**159,561**	**148,248**	**154,448**	**154,736**	**140,892**	**126,494**

Statement of Cash Flows

$000s

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Cash Flows from Operating Activities						
Operating Income	644,966	690,730	725,207	751,982	782,061	813,345
Operating Expenditure	632,610	684,233	725,146	749,349	779,323	810,496
Net Cash from Operating Activities	12,355	6,496	61	2,633	2,738	2,849
Cash Flows from Investing Activities						
Interest receipts 3rd Party	841	601	200	208	216	225
Sale of Fixed Assets	22	18	-	-	-	-
Purchase of Fixed Assets	(16,996)	(22,805)	(33,641)	(24,870)	(11,270)	(12,793)
(Increase)/Decrease in Investments and Restricted & Trust Funds As	(1,707)	(1,629)	(740)	(0)	(0)	(0)
Net Cash from Investing Activities	(17,840)	(23,815)	(34,181)	(24,662)	(11,054)	(12,568)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	6,600	19,000	13,600	-	-
Borrowings introduced (repaid)	(712)	7,320	(898)	(589)	(465)	(343)
Interest Paid	(71)	(126)	(469)	(487)	(507)	(527)
Other Non-Current Liability Movement	-	(2)	-	-	-	-
Net Cash from Financing Activities	(783)	13,792	17,633	12,524	(972)	(870)
Net Increase/(Decrease) in Cash held	(6,267)	(3,526)	(16,487)	(9,505)	(9,287)	(10,589)
Add opening cash balance	12,707	6,439	2,913	(13,574)	(23,079)	(32,367)
Closing Cash Balance	6,439	2,913	(13,574)	(23,079)	(32,367)	(42,956)

Note: *Cash balance includes short term investments which are considered cash or cash equivalents*

Key Financial Analysis and Banking Covenants

	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	98,231	117,606	125,648	134,564	143,386
Debt	1,775	9,095	8,197	7,608	7,143
Owners Funds	159,561	148,248	154,448	154,736	140,892
Total Assets	257,792	265,854	280,095	289,300	284,278
Owners Funds to Total Assets	61.9%	55.8%	55.1%	53.5%	49.6%
Interest Expense	71	126	469	487	507
Depreciation Expense	12,993	14,030	15,063	15,665	16,292
Surplus/(Deficit)	(10,787)	(17,919)	(12,800)	(13,312)	(13,844)
Interest Cover	32.24	- 29.94	5.83	5.83	5.83
Debt/Debt + Equity Ratio	1%	6%	5%	5%	5%
Banking Covenants					
Debt/Debt + Equity Ratio	1.1%	5.8%	5.0%	4.7%	4.8%
Interest Cover	32.2	- 29.9	5.8	5.8	5.8
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Devolved Funding	605,727	655,769	685,705	713,133	741,658	771,325
MOH Non-Devolved Contracts (provider arm side contracts)	14,471	15,556	14,789	15,381	15,996	16,636
Other Government (not MoH or other DHBs)	7,185	6,778	6,393	6,648	6,914	7,191
Patient / Consumer sourced	637	834	449	466	485	505
Other Income	5,048	5,052	3,539	3,681	3,828	3,981
InterProvider Revenue (Other DHBs)	1,326	1,253	1,190	1,238	1,287	1,339
IDFs - All Other (excluding Mental Health)	9,907	10,881	11,195	11,643	12,109	12,593
Total Consolidated Revenue	644,300	696,123	723,260	752,190	782,278	813,569
Personnel Costs	235,137	268,710	277,190	288,277	299,809	311,801
Outsourced Services	34,736	40,343	35,641	37,066	38,549	40,091
Clinical Supplies	49,767	52,956	54,877	61,655	64,121	66,686
Infrastructure & Non-Clinical Supplies	29,130	31,234	32,177	28,875	30,392	32,820
Finance Costs	8,535	9,408	9,600	9,991	10,027	9,217
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Personal Health	186,749	195,810	202,212	210,301	218,713	227,461
Mental Health	15,964	16,841	19,956	20,754	21,584	22,448
Disability Support Services	74,638	77,546	81,201	84,450	87,828	91,341
Public Health	1,734	1,722	1,790	1,862	1,936	2,014
Maori Health	5,704	5,442	6,352	6,606	6,870	7,145
Total Operating Expenditure	655,087	714,042	736,059	765,502	796,122	827,967
Surplus (Deficit)	**(10,787)**	**(17,920)**	**(12,800)**	**(13,312)**	**(13,844)**	**(14,398)**

Provider Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	14,471	15,556	14,789	15,381	15,996	16,636
Other Government (not MoH or other DHBs)	6,825	6,778	6,393	6,648	6,914	7,191
Non-Government & Crown Agency Sourced	5,685	5,886	3,988	4,147	4,313	4,485
InterProvider Revenue (Other DHBs)	1,326	1,253	1,190	1,238	1,287	1,339
Internal Revenue (DHB Fund to DHB Provider)	333,227	364,498	385,956	401,394	417,450	434,148
Total Provider Revenue	361,533	393,972	412,316	428,808	445,961	463,799
Personnel Costs	235,137	268,710	277,190	288,277	299,809	311,801
Outsourced Services	34,736	40,343	35,641	37,066	38,549	40,091
Clinical Supplies	49,767	52,956	54,877	61,655	64,121	66,686
Infrastructure & Non-Clinical Supplies	28,804	30,888	31,594	28,269	29,762	32,164
Finance Costs	8,535	9,408	9,600	9,991	10,027	9,217
Depreciation	12,993	14,030	15,063	15,665	16,292	16,944
Total Operating Expenditure	369,973	416,334	423,964	440,923	458,560	476,902
Surplus (Deficit)	**(8,439)**	**(22,362)**	**(11,649)**	**(12,115)**	**(12,599)**	**(13,103)**

Governance Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
Government & Crown Agency Sourced	368	(0)	(0)	(0)	(0)	(0)
Total Governance Revenue	368	(0)	(0)	(0)	(0)	(0)
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	325	347	583	606	630	655
Total Operating Expenditure	325	347	583	606	630	655
Surplus (Deficit)	**43**	**(347)**	**(583)**	**(606)**	**(630)**	**(655)**

Funder Statement of Financial Performance ($000s)	2017-18 Audited Actual	2018-19 Forecast	2019-20 Budget	2020-21 Budget	2021-22 Budget	2022-2023 Budget
MOH Devolved Funding	605,727	655,769	685,705	713,133	741,658	771,325
Inter District Flows	9,907	10,881	11,195	11,643	12,109	12,593
Total Funder Arm Revenue	615,994	666,649	696,900	724,776	753,767	783,918
Personal Health	470,476	507,191	535,594	557,017	579,298	602,470
Mental Health	58,193	62,125	64,696	67,284	69,975	72,774
Disability Support Services	80,913	84,407	88,063	91,585	95,249	99,059
Public Health	2,504	2,362	2,431	2,528	2,629	2,734
Maori Health	5,929	5,774	6,685	6,953	7,231	7,520
Other	368	-	-	-	-	-
Total Operating Expenditure	618,384	661,859	697,468	725,367	754,382	784,557
Surplus (Deficit)	**(2,390)**	**4,790**	**(568)**	**(591)**	**(614)**	**(639)**

Statement of Financial Performance - By Output Class $000s	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Budget 2019/2020
DHB Provider Revenue	366,029	30,976	0	0	412,316
Other Provider Revenue	3,072	2,455	4,124	1,545	11,195
DHB Funder Revenue	93,062	124,472	10,959	71,255	299,749
Total SOI Revenue	462,163	157,902	15,084	72,800	723,260
Personnel Costs					
Medical Labour	73,289	7,311	1,642	37	82,280
Nursing Labour	91,491	8,335	2,043	5,487	107,357
Allied Health Labour	26,177	12,109	2,693	2,743	43,722
Non Clinical Support Labour	5,403	179	139	90	5,811
Management and Admin Labour	29,179	4,179	2,832	1,831	38,020
Non-Personnel Operating Costs					
Outsourced Services	29,341	4,277	1,248	774	35,641
Clinical Supplies	53,274	2,315	691	3,004	59,284
Infrastructure and Non Clinical	35,308	3,979	1,660	1,886	42,833
Finance and Capital Costs	8,054	852	298	395	9,600
Provider Payments					
Personal Health	77,362	118,354	5,460	1,036	202,212
Mental Health	16,765	3,191	0	0	19,956
Disability Support Services	171	0	0	81,030	81,201
Public Health	0	1,405	386	0	1,790
Maori Health	0	619	5,661	72	6,352
Total SOI Operating Expenditure	445,812	167,106	24,754	98,387	736,059
Surplus (Deficit)	**16,350**	**(9,204)**	**(9,671)**	**(25,587)**	**(12,800)**

Significant Accounting Policies

Reporting entity

Northland District Health Board (Northland DHB) is a Health Board established by the New Zealand Public Health and Disability Act 2000. Northland DHB has designated itself as a Public Benefit Entity (PBE) for financial reporting purposes. It is domiciled and operates in New Zealand. Northland DHB is a Crown Entity as defined by the Crown Entities Act 2004. Northland DHB's ultimate parent is the Crown.

Northland DHB's activities involve funding and delivering health and disability services in a variety of ways to the community.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZGAAP). They have been prepared in accordance with Tier 1 PBE Accounting Standards. These financial statements comply with PBE accounting standards.

Presentation currency

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

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE accounting standards requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and

associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

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

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 useful lives and residual values of property, plant and equipment

The useful lives and residual values of property, plant and equipment are reviewed at each balance date. Assessing the appropriateness of useful life and residual value estimates requires Northland DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by Northland DHB, and expected disposal proceeds (if any) from the future sale of the asset.

Critical judgments in applying accounting policies

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the Northland DHB.

Judgment 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.

Northland DHB has exercised its judgement on the appropriate classification of leases, and has classified finance lease appropriately.

Foreign currency transactions

Transactions in foreign currency are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Cash and cash equivalents

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

Trade and other receivables

Short-term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that Northland DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Trade and other payables

Trade and other payables are recorded at their face value.

Investments

Bank term deposits

Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the average weighted cost method) and 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.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of cost (using the average weighted cost method) and net realisable value.

Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Interest bearing borrowings

Interest bearing borrowings are recognised initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest bearing borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis. Borrowings are classified as current liabilities unless Northland DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Property, plant and equipment

Property, plant and equipment consists of the following asset classes: land, buildings and plant, equipment and motor vehicles.

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and accumulated impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, of the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are revalued to fair value as determined by an independent registered valuer at least every three years or where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive revenue and are accumulated to an asset 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 but is recognised in the surplus or deficit.

Any subsequent increase on revaluation that offsets 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.

Accumulated depreciation at revaluation date is eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Property, plant and equipment vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Northland Health Limited (a hospital and health service company) were vested in Northland DHB on 1 January 2001. Accordingly, assets were transferred to Northland DHB at their net book values as recorded in the books of the hospital and health service. In effecting this transfer, the Northland DHB has recognised the cost and accumulated depreciation amounts from the records of the hospital and health service. The vested assets will continue to be depreciated over their remaining useful lives.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus or deficit in the period in which the transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

The cost of an item of property, plant and equipment is recognised as an asset if it is probable that future economic benefits or service potential associated with the item will flow to Northland DHB and the cost of the item can be measured reliably.

In most instances, an item of property, plant and equipment is recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred, if it is probable that the service potential or future economic benefits embodied within the new item will flow to Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. 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 using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	Estimated life	Depreciation rate
Buildings (including components)	10 to 70 years	(1.4% - 10%)
Plant and equipment	1 to 15 years	(6.6% - 100%)
Motor vehicles	5 to 15 years	(6.6% - 20%)

The residual value of assets is reassessed annually to determine if there is any indication of impairment.

Work in progress is recognised at cost less impairment and is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Borrowing costs

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

Intangible Assets

Intangible assets that are acquired by Northland DHB are stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific asset.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs can include the software development employee costs and an appropriate portion of relevant overheads.

Finance Procurement Supply Chain, including National Oracle Solution

The Finance Procurement Supply Chain (FPSC), which includes the National Oracle Solution (NOS), is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Northland DHB holds an asset at cost of capital invested by Northland DHB in the FPSC programme. This investment represents the right to access the FPSC assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and is tested for impairment annually.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalised only when it increases the service potential or future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

Amortisation is provided in the surplus or deficit on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Intangible assets with an indefinite useful life are tested for impairment at each balance sheet date. Other intangible assets are amortised from the date they are available for use.

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	(33% - 50%)

Impairment of property, plant and equipment and intangible assets

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

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment. Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. 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 depreciated replacement cost for an asset where the fair value of an asset cannot be reliably determined by reference to market based evidence. Specialised Hospital Buildings are an example of this.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive revenue to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Employee benefits

Defined contribution schemes

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits 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 for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave and retirement gratuities

Northland DHB's obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated on an actuarial basis and involves the projection, on a year by year basis, of the entitlements, based on accrued service. These benefits are estimated in respect of their incidence according to assumed rates of death, disablement, resignation and retirement and in respect of those events according to assumed rates of salary progression. A value is placed on the resulting liabilities by discounting the projected entitlements back to the valuation date using a suitable discount rate. All other employee entitlements are classified as current liabilities.

Annual leave, conference leave and medical education leave and expenses

Annual leave, conference leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Northland DHB expects to pay. These are recognised in the surplus or deficit when they accrue to employees. Northland DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

Sick leave

Northland DHB recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent the Northland DHB anticipates it will be used by staff to cover those future absences.

Bonuses

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 constructive obligation and a reliable estimate of the obligation can be made.

Provisions

A provision is recognised at fair value when Northland DHB has a present legal or constructive obligation as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and that a reliable estimate can be made. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability. The movement in provisions are recognised in the surplus or deficit.

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 for which implementation has already commenced.

ACC Accredited Employers Programme

Northland DHB belongs to the ACC Accredited Employers Programme (the "Full Self Cover Plan") whereby Northland DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Northland DHB is liable for all claims costs for a period of two years after the end of the cover period in which the injury occurred. At the end of

the two-year period, Northland DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Accredited Employers Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the 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.

Equity

Equity is the community's interest in Northland DHB and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into a number of components.

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), Fair value through other Comprehensive Revenue Reserve (Bond Investments), non-controlling interest in the group and Trust/Special Funds. The minority interest in the group is represented by the joint venture partner in the controlled entity. Trust/Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Property revaluation reserve

This reserve relates to the revaluation of property, plant, and equipment to fair value.

Fair value through other comprehensive revenue and expense reserves

This reserve comprises the cumulative net change of financial assets (Bond Investments) classified as fair value through other comprehensive revenue and expense.

Revenue

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

Ministry of Health population-based revenue

Northland DHB receives annual funding from the Ministry of Health, which is based on population levels within the Northland DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Ministry of Health Contract Revenue

The revenue recognition approach for Ministry of Health 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 Northland 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 periods 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.

Goods sold and services rendered

Revenue from goods sold is recognised when Northland DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Northland DHB does not retain either

continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

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

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Northland DHB region is domiciled outside of Northland. The Ministry of Health credits Northland DHB with a monthly amount based on an estimated patient treatment for non-Northland residents within Northland. An annual wash-up occurs at year end to reflect the number of non-Northland patients treated at Northland DHB.

Donated services

Certain operations of the Northland DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Northland DHB.

ACC contract revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Rental revenue

Rental revenue is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental revenue over the lease term.

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

An operating lease is a lease whose term is short compared to the useful life of the asset or piece of equipment and does not transfer substantially all the risks and rewards incidental to ownership of the asset to the lessee.

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

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 Northland 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.

Financing costs

Net financing costs comprise interest paid and payable on borrowings, calculated using the effective interest rate method and are recognised as an expense in the financial year in which they are incurred.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates. The intention of the capital charge is to make explicit the true costs of the taxpayers' investment by requiring recognition of those costs.

Contingent liabilities

Contingent liabilities are recorded in the Statement of Contingent Liabilities at the point at which the contingency is evident. Contingent liabilities are disclosed if the possibility that they will crystallise is not remote.

Cost allocation

Northland DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below:

Cost allocation policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Income tax

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

Goods and services tax

All items in the financial statements are presented exclusive of 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 Inland Revenue Department (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 an operating cash flow in the statement of cash flows.

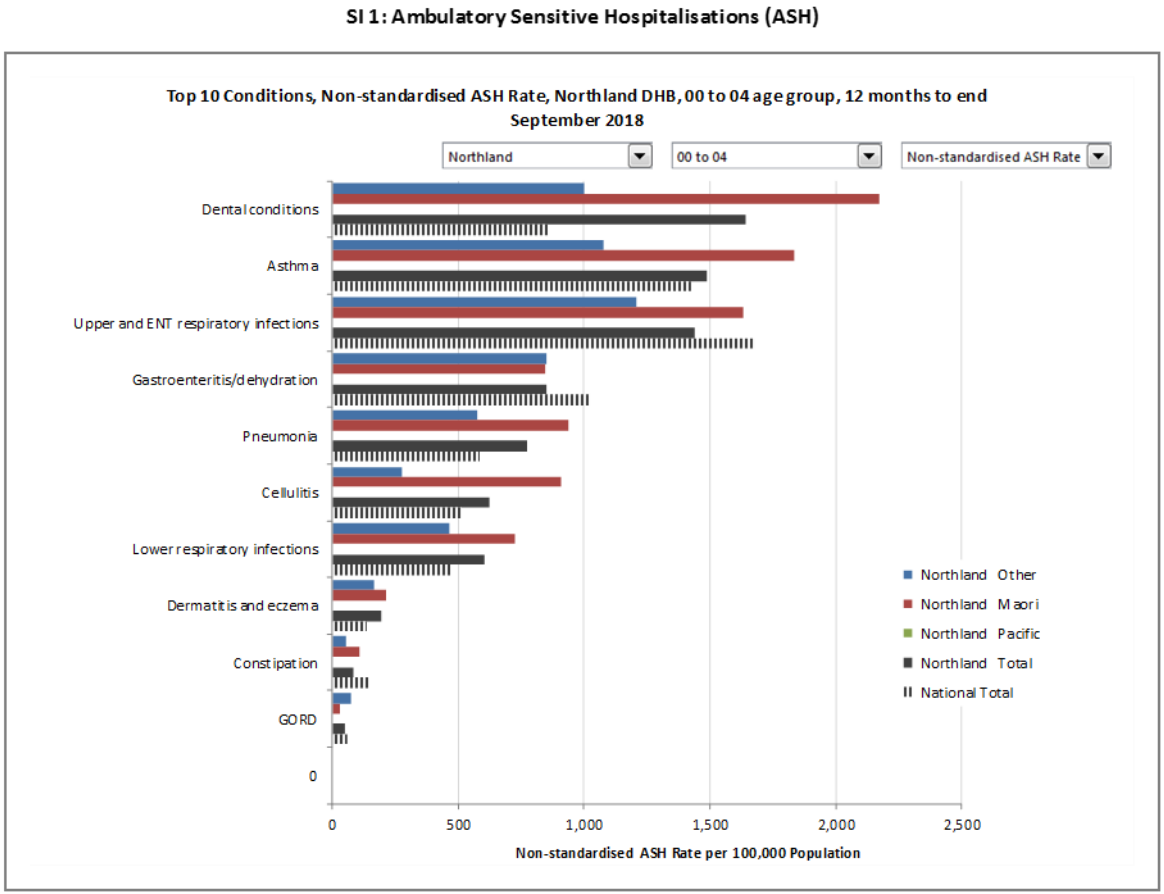
Commitments and contingencies are disclosed exclusive of GST.

Appendix: System Level Measures Improvement Plan 2019/20

20 June 2019 draft

Ambulatory Sensitive Hospitalisations for 0-4 year olds SLM plan 2019/2020

Current Northland status is displayed below.



For 2019/2020 our actions will focus on the National Child Health Information Platform (NCHIP) solution and the establishment of Te Māhuri – the coordination service informed by NCHIP.

NCHIP enables providers to view a dashboard of all the universal milestone checks that a child 0-6 years of age is entitled to receive. It will enable providers to have a view on which services are engaged with tamariki and where services may require support to engage with whānau. Providers will be able to see a more detailed view for children who are enrolled with their service.

Te Māhuri using the NCHIP solution aims to become a key enabler in ensuring that the various universal health service providers and families with

children under five years old are connected and that milestones checks, screening and immunisations are completed. Its main task is to close the gap for that percentage of children who are missing out on receiving free health services delivered in a timely manner. The service will follow up with the families and health providers when children are late or missing enrolment or their health milestones. The service will also generate reports on the integrated dataset for tracking overall performance, supporting services, and finding children who are missing out on services.

The Coordination Service will have a widespread network to find children including an established relationship under shared MOUs with Ministry of Social Development and Ministry of Education.

We plan to expand the scope of the current "virtual" MDT process for children with high ED utilisation/admission for respiratory ASH.

The MDT will be informed by NCHIP and working collaboratively with primary and secondary providers of child health services, take a proactive approach toward mitigating access barriers for priority groups of children such as:

- those who remain unenrolled or have poor engagement with universal child health services despite lower level intervention
- children with frequent utilisation of acute services for top ASH coded conditions (e.g. oral, respiratory, skins and gastroenteritis)
- children with recurrent DNA to outpatient services
- infants of mothers who have been working with Te Whare Ora Tangata (maternal and infant care coordination forum) during pregnancy
- children who are with Oranga Tamariki.

NCHIP and Te Māhuri have a comprehensive set of performance indicators to measure progress and effectiveness of this approach.

These activities will be guided by the Regional Working Group for NCHIP which includes a communications plan, workforce development plan and management of the enhancements required for the database.

Milestones	**Activities** *Ambulatory Sensitive Hospitalisations 0-4 years outcomes will be improved by these activities, which link and will benefit the outcomes for the Babies Living in Smokefree Homes plan.*	**Contributory Measures** *All data is viewed by ethnicity and quintile. Focus is on improving access to primary care services for tamariki Māori and quintile 5 children.*
Reduce the number of tamariki Māori aged 0-4 years ASH conditions by 3%.	Implement the National Child Health Information Platform (NCHIP) database across Te Tai Tokerau. Implement the Child Health Integration Hub (Te Māhuri) to support access of priority tamariki and whānau into universal services. This will include a triaged assessment approach inclusive of an intersectoral taskforce for priority children 0-6 years. E.g. "children lost to services/recurrent DNAs, children with high ED utilisation, ASH readmissions, and children in Oranga Tamariki. Prioritise infants under 2 years old with recurrent respiratory ASH for proactive case management in Te Māhuri MDT and prioritised access to respiratory nurse specialist and paediatric specialist services such as SLT assessment and paediatric review.	10% increase number of Māori infants enrolled in a Primary Health Organisation by three months from 77% to 87%. *(Newborns born in the following period: 19 May 2018 to 19 Aug 2018. Q1 2018)* 10 % increase number of Māori babies receiving the first three core checks 1-3 from 55% in Nov 2018 to 65% by June 2020 15 % reduction in # of children under 2 years with >1 readmission for acute bronchiolitis within a 12-month period 10 % reduction # of children under 2 years with >1 readmission for asthma within a 12-month period

Acute Bed Days SLM Plan for 2019/20

Where we have come from & where we are heading

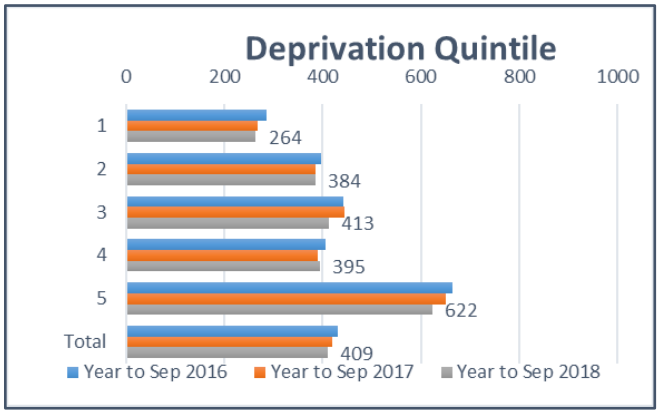
Northland DHB and Northland's PHOs are working collaboratively to provide co-ordinated, innovative models of integrated, patient centred- care that will reduce acute bed days. Our approach continues to pursue a flexible, quality health system delivering the most appropriate care in the most appropriate setting. 33.5% of total Northland population is of Māori ethnicity, this increases to 49% of Te Tai Tokerau PHO population and thought to be as high as 75% in some localities. It is identified that these areas of high Māori population also tend to be the areas of most deprivation which are quintiles 4 and 5. It is also known that both Māori/Pacific and the most deprived quintile groups are over represented in Long Term Condition statistics, with respiratory featuring high on the list for Acute Bed Days (admissions and readmissions) consistently across all Northland hospitals, hence the focus for the Acute Bed Days System Level Measure for 2019-2020.

The two Northland PHOs are transforming into a new Primary Health Entity on the 1st July 2019 – Te Kaupapa Mahitahi Hauora. One of the primary functions and principles of this is to bring an increased focus on addressing key areas based on local needs to: decrease disparity and inequality in the health status of Māori and Pacific Islanders; enhance the patient experience for patients and whānau; and improve resource effectiveness across Northland's geographical challenging region. A key focus will be on addressing locality need by identifying populations of highest risk/need and tailor service provision accordingly.

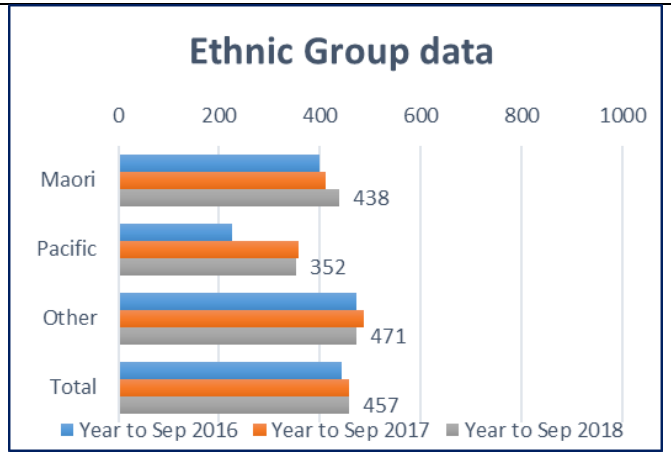
The intention of the activities of this System Level Measure is to ultimately provide an individualised wrap around level of care and access to services to all patients who have been discharged from hospital following an exacerbation of their chronic respiratory condition. However, priority and focus, for some activities, will initially be directed to those identified as The Priority Group*. (*Reside in area identified as quintile 4 or 5, or of Māori/Pacific ethnicity).

Deprivation Quintile Comparison Northland - Actual Acute Bed Days per 1000 population

Ethnic Group data Northland- Actual Acute Bed Days per 1000 population.



	Est. Pop.	Acute Stays	Acute Bed Days	Actual Acute Bed Days per 1,000 Pop.		
	Year to Sep 2018	Year to Sep 2018	Year to Sep 2018	Year to Sep 2016	Year to Sep 2017	Year to Sep 2018
Māori	58,483	8,461	25,586	399	412	438
Pacific	2,977	420	1,048	225	357	352
Other	103,640	13,828	48,818	473	487	471
Total	165,101	22,709	75,453	443	458	457



Further analysis of Northland data shows:

- Māori have used half of the acute bed days in Northland between 2016 and 2019, (9164 out of the total of 18145).
- Quintile 5 Māori represent 6427 (35.4%) of the 18,145 bed days for respiratory conditions.

The age groups with highest number of bed days are:

- 0-15 years: 5721 (31.5%) bed days, with almost a quarter (1435) for Whooping Cough/Acute Bronchitis (half of whom are Q5 Māori).
- 41-64 years: 5876 (32.4%) bed days, with 54.6% of those bed days due to respiratory infection/inflammation (1729 days) and COPD (1481 days)
- 65-74 years: 5505 (30.3%) bed days, with 62.6% of those bed days due to COPD (1900), and respiratory infection/inflammation (1547)

The ages with the highest bed days for Māori are:

- 0-15 (3684 bed days)
- 41-64 (2911 bed days)
- 65-74 (1876 bed days).

Almost all these bed days are being used by Q4 and Q5 (mostly Q5).

If we look at non-Māori, the numbers shift considerably, with much lower number of 0-15 year olds (1794 bed days), and higher 41-64 (2883 bed days) and 65-74 year olds (3580 bed days). While Q5 non-Māori still require more bed days that Q4 and lower, there is significantly less variation across the quintiles compared to for Māori.

Milestone	Activities	Contributory Measures
Reduce acute bed days for those identified as within The Priority Group by 3% by 30 June 2020.	General Practices to use POADMS – Primary Options Acute Demand Service (where appropriate) to provide treatment to patients who otherwise would be referred to hospital due to the exacerbation of their chronic respiratory condition. The POADMS Clinical Co-ordinator will be advised of hospital	Increase use of POADMS to provide appropriate treatment closer to home. Reduce the incidence of readmission for adults with chronic respiratory conditions Increased referral rate for patients with Chronic Respiratory Conditions to the Outreach Respiratory

	based nurse will see all patients identified within the Priority Group* being discharged from Whangārei District Hospital following admission for exacerbation of their chronic respiratory condition to ensure co-ordination to primary care services is in place following to discharge. Patients identified as within the Priority Group* with chronic respiratory conditions who are admitted to hospital will be referred to the Respiratory Outreach Team on discharge. General Practice, upon receiving a discharge summary for patients who have been admitted with an exacerbation of their chronic respiratory condition will enrol the patient in Kia Ora Vision (if consented) and offer and initiate a Whānau Tahi careplan, if not already in place.	Team. Increased enrolment rates into Kia Ora Vision. Whānau Tahi careplans (if consent given) in situ for all patients who have been admitted with an exacerbation of their Chronic Respiratory Condition.

Amenable Mortality SLM Plan for 2019/20

Where we have come from & where we are heading

Northland DHB and PHOs and NGOs remain committed to working together to improve the equity disparity that exists for Māori and particularly Māori males in Northland. Māori represent a significant proportion of the Northland population; 33.5% compared to 15.6% for the rest of NZ. Māori are a predominantly younger cohort but due to premature death there is a sharp decline in population numbers from the age of 69. Unfortunately, Māori are over represented in statistics related to disease and disease progression, acute admissions related to cardiovascular disease remain in the top 10 presentations for Māori males aged between 0-74 years across Northland and Māori adults have a diabetes prevalence rate of 7.4%, approximately 2% higher than the rest of New Zealand.

We are committed to identifying early those people who through effective communication, easier better access and consistent appropriate clinical management will have improved health outcomes and live longer healthier lives.

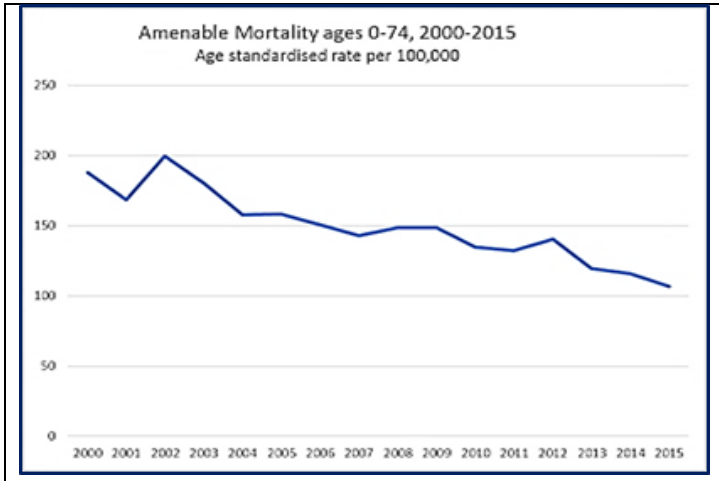
Total population eligible for CVRA check as at 14 Feb 2019 (data source: Predict)

data source: Predict Extract Jan 2017-Dec 2018

	Maori	Non Maori	Total
Total Checks Jan 2017-Dec 2018	15527	35967	51494
Total Checks Q5	9076	8710	17786
Patients with CVD risk >=15%	8127	14064	22191
	52%	39%	43%
Quintile 5 >=15%	5083	3981	9064
	56%	46%	51%
with CVD risk >15% on Anti Hypertensive	4841	7487	12328
	60%	53%	56%
Q5 CVD risk >15% on Anti Hypertensive	3168	2343	5511
	62%	59%	61%
Patients with HbA1c>64	2420	2166	4586
Patient on Anti Hyperglycaemic	1756	1391	3147
	73%	64%	69%
Q5 with HbA1c>64	1666	775	2441
Q5 on Anti Hyperglycaemic	1218	530	1748
	73%	68%	72%

MSO - NPHOS

Ethnicity	A	B1	C	D
	Eligible	Screened	% Screened	Target
Maori	19179	15103	79%	17261
Pacific Island	1010	788	78%	909
Indian Sub-Continent	947	643	68%	852
Other	39996	34809	87%	35996
Not Stated	91	66	73%	82
Total	61223	51409	84%	55101



Insert updated data from baseline 2014 to 2016 for milestone when data published by MoH

The activities we will implement for this improvement plan focus on addressing access, engaging and supporting the General Practice workforce, providing tools to easily identify patients with highest clinical risk and a platform that supports shared communication and Interdisciplinary planning.

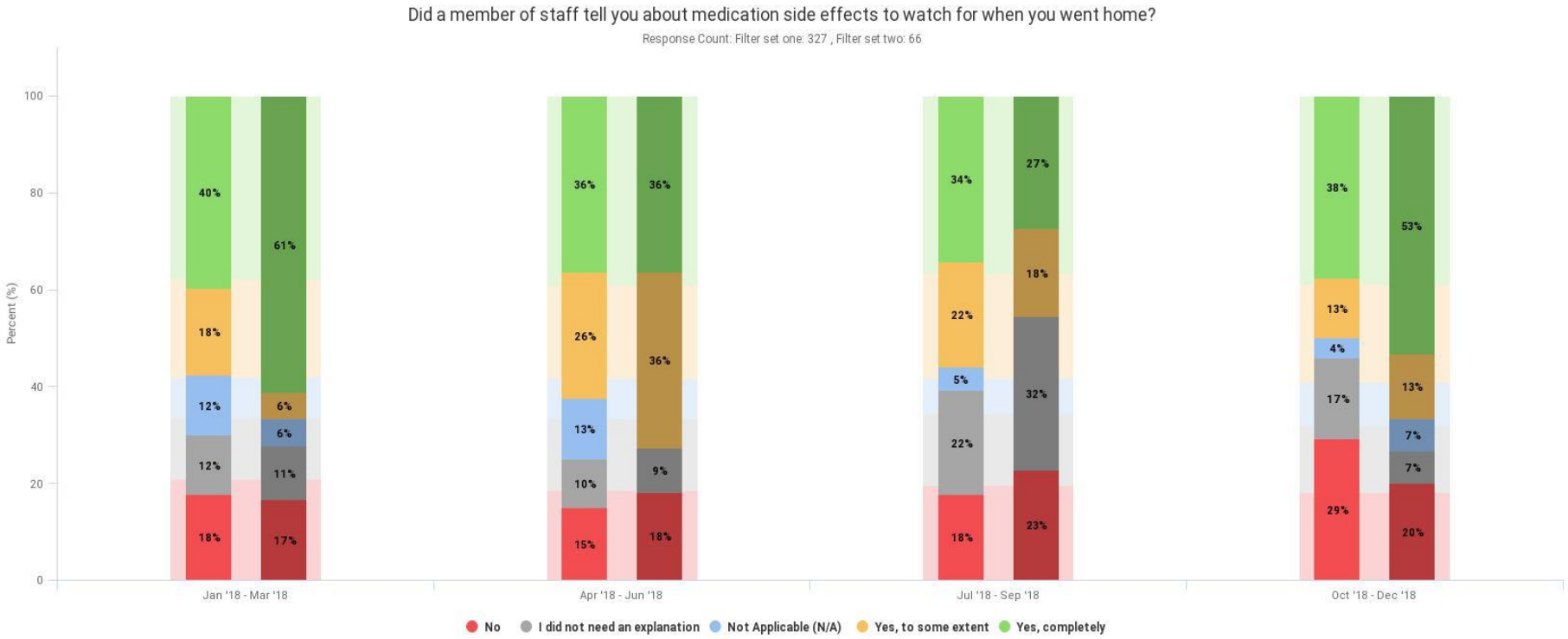
Milestone	Activities	Contributory Measures
Reduce the amendable mortality rate for Māori by 20% by 2021.	Implement NHH model of care into twelve practices across Northland by June 2020 Monitor NHH practices progress against the 4 Model of Care domain requirements Engage general practice in end tester using of the new CVDDM7 tool and complete by Dec 2019 By December 2019 provide general practice and other community providers with updated best practice education for management of CVD and/or DM in our eligible Northland population Embed CVDDM7 as a screening and management tool into all Northland general practices by June 2020 Identify at practice level those patients with modifiable clinical risk and support self-management with shared multidisciplinary shared care planning Refine the risk stratification tool by Dec 2019 to enable easier identification by general practice of their individual patients at higher clinical risk population Secondary care specialist services will increase their	Key recorded performance measures will be monitored quarterly identifying trend improvement e.g. equity, access and triage PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years Improved Management of long term conditions (Diabetes) – WT shared care plans HbA1c test results – hyperglycaemia and appropriate clinical management General practice will have current or updated Whānau Tahi (WT) shared care plans for a minimum of 80% of their eligible Māori population by June 2020, for each 12-month period. Monitoring and identification of new service users and service usage will be reported by the coordinator via the Whānau Tahi Implementation working group MDT participation across the sector will be monitored by the relevant workstreams eg. Nurse Navigator and NHH primary care led MDT standards

	access and participation into WT shared care plans by June 2020. Secondary services will increase their participation in MDT for people with complex need under their services e.g. cardiology, diabetes, renal, ED, medical, mental health by June 2020	

Patient Experience of Care

Inpatient Survey

The current participation rate for the **inpatient survey** is around 16% overall and has remained unchanged over the past 2 years. In 2018 there were 327 responses for 'Did a staff member tell you about medication side effects to watch for when you went home?' Of these, 66 (20%) respondents were Māori, and NDHB scored an aggregate of 6.1 in this period. This is the lowest scoring question in the survey. Focus will now move to improvement work that addresses this question. Northland has been identified in the Health Atlas as being an outlier for prescribing of opioids. Both the PHO and DHB recently attended the 'Opioid Stewardship' HQSC workshop to look at a system wide approach to reducing harm from opioid prescribing. Granular understanding of systemic gaps is poorly understood and both DHB and PHO have requested more localised data be made available from the Atlas to drive improvement. In the interim Northland continues to be engaged in this national discussion and has chosen to focus on opioids as an area to reduce harm and educate on side effects at discharge.



Primary Care Patient Experience Survey

Nov 2018	Manaia PHO			Te Tai Tokerau PHO		
	Māori	Non-Māori	Total	Māori	Non-Māori	Total
Number Invited	445	2798	3243	279	1087	1366
% Invited	14%	86%	100%	20%	80%	100%
Number Respondents	82	780	862	41	260	302
% Invited + Responded	18%	28%	27%	15%	24%	22%
Total Number Invited (all ethnicities)		3243			1366	
Number Respondents (all ethnicities)		862			302	
% Invited + Responded (all ethnicities)		27%			22%	

Data from the November 2018 **Primary Care Patient Experience survey** is summarised above. This shows that 3243 Manaia PHO patients were invited to complete the survey and 862 people completed it. Of these, only 445 Māori were invited, and 82 completed the survey. Response rate = 27% overall, 18% Māori and 28% non-Māori.

Similarly, Te Tai Tokerau data shows a total of 1366 people invited, with 302 completed responses. Of these, only 279 Māori were invited and 41 completed a response. Response rates = 22% overall and 15% Māori.

During the week of the November 2018 survey only 14% (445 of 3243) of MPHO patients who attended general practice were Māori, and 27% of all MPHO patients identify as Māori. Similarly, only 20% (279 of 1366) of TTT patients attending during survey week were Māori, and 48% of all TTT patients identify as Māori. It is unclear if this low proportion of Māori presentations was an anomaly for that particular week, or if there is a disproportionate number of Māori presenting to general practice in Northland. It will be important to look at this once we collect more data with future quarterly surveys.

The focus of the 2019-20 plan is to use the results of the surveys to make changes that improve patient experience of care.

We acknowledge that Māori response rates have been low and we would like to increase these. However, we would be unlikely to see an improvement without changes being made to the accessibility and format of the survey.

While this plan supports the National Primary PES survey, the survey can only be completed post GP visits for the audience selected. Access in Northland via WIFI isn't ideal, especially in rural areas so format and delivery, with 10-30 minutes needed to complete the PES is not practical. Face to face contact and asking questions from a short survey as Māori patients are walked out post appointment may be an effective way to capture responses and genuine feedback to address the equity gap. Key questions such as those from the ORS Outcome Rating Scale, which capture the essentials of what's right for the patient would be more effective in capturing the increased key feedback by Māori patients that we need to address equity issues in Northland. Also of

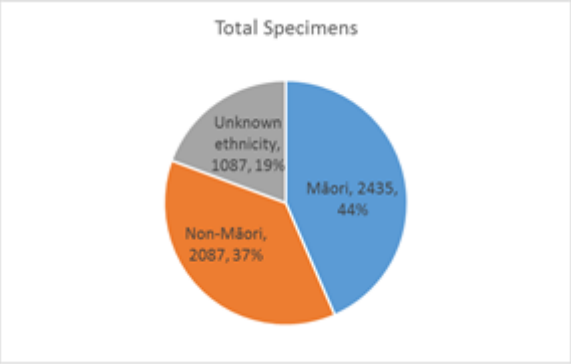
note, the PES survey does also not capture the population using Iwi Providers.

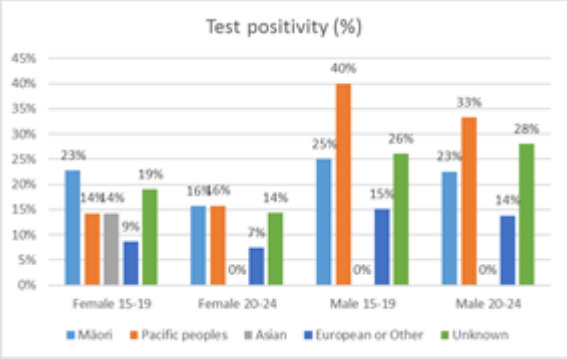
Milestones	Activities	Contributory Measures
Improve patient understanding of medication side effects on the **inpatient** survey by 5% by 30 June 2020.	Work with the HQSC to look at a systems wide approach in reducing harm from opioid prescribing.	Reduction of opioid prescribing within the Northland region.
Maintain overall response rates of 24% for completed **Primary Care** PES.	Maintain response rates by: having the survey available in formats other than email such as kaiāwhina to visit patients in the community to facilitate them to complete surveys; reminding patients that family members can complete survey on their behalf; give **all** patients PES leaflets in English and Te Reo Māori during the survey week; ensure patient email addresses are current.	**Primary Care** PES overall response rates are maintained at or above 24% over the next 12 months.
Work with 25% of practices to review their lowest scoring questions to improve patients' experience of care.	Work with practices to review their low scoring PES results and use these as a focus for developing activities to raise these particular scores, to improve patients' experience of care. There will be a strong focus on inequities and concerns that have come through in the patient stories.	Patient experience of care is improved at practice level. Examples of this may include: the number of patients involved in developing their long-term condition care plans is increased, the number of patients who cannot see a GP due to cost is decreased, the rating for the time taken to get to see the doctor is increased (an increase may be due to education about expectation rather than reducing the wait time). These variables can be measured before and after the focused activity to see improvements in patient experience of care

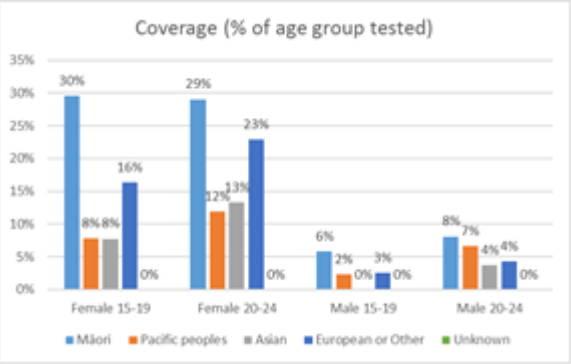
Youth Health SLM Plan for 2019/2020

Youth access to and utilisation of youth appropriate health services. Northland has established a Hub and Spoke one team model in partnership with the DHB, YOSS, GP's and Iwi Providers to provide youth specialist services into all Northland Schools.

Governance and Operational working group established, SLM improvement plans is a rolling Agenda item. Data has been reviewed through Governance: Self Harm, ED Alcohol related presentation are lower than national rates other than in the younger age group for self-harm (10-14yo) and with Primary Mental health involvement we are taking strength based group approaches with group programs targeted at younger females being piloted in Kaikohe currently for year 9-11 girls to build resiliency.- We will continue to monitor rates and measure outcomes from current programs and roll out further if successful.

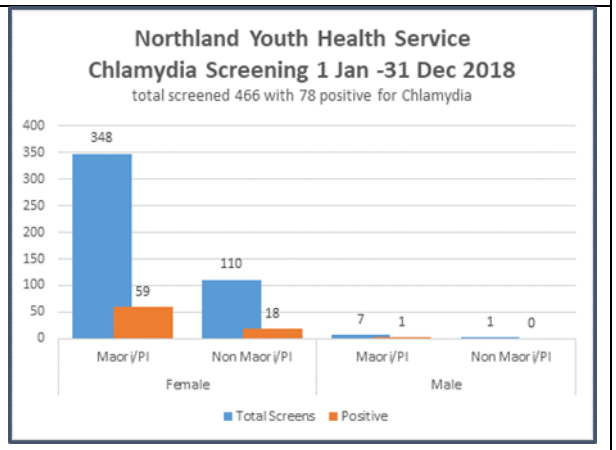






Oral Health Utilisation is concerning as it is low already but reducing not increasing. Governance will agenda this as a priority in early 2020.

Chlamydia screening continues to be low and rates of infection for Māori are high. The Governance group are monitoring our up to date Youth Health Database for Chlamydia screening rates and positive rates. The ESR data is delayed, only 2016 data is currently available Milestones are based this data.

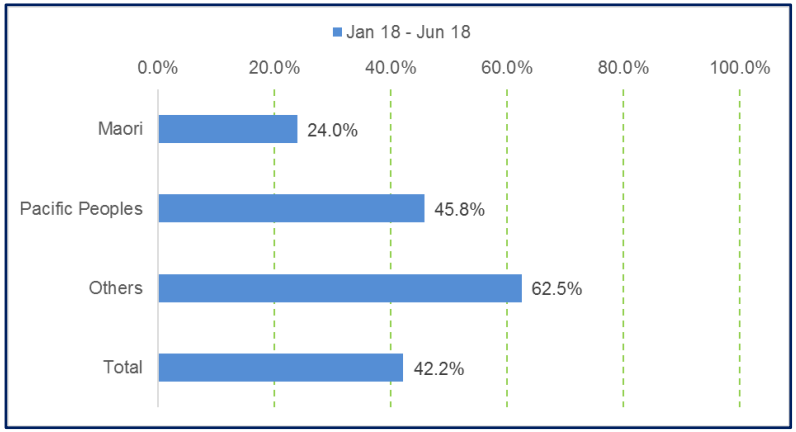


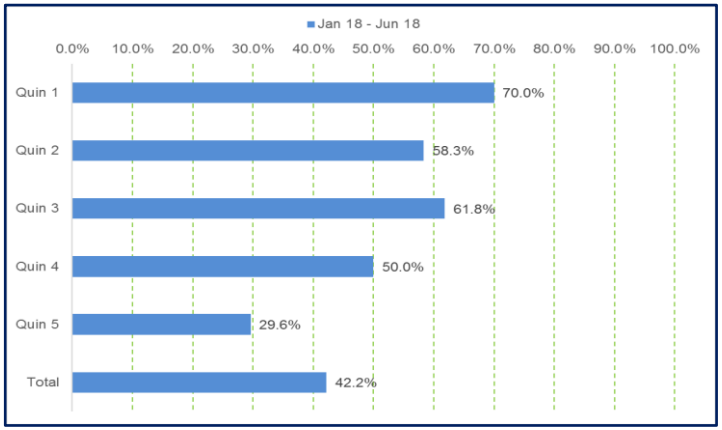
Milestone	Activities	Contributory Measures

Sustained and incremental increase in Chlamydia testing coverage for 15–24 year olds. ESR Chlamydia Test Coverage % to rise to 10% for Males and 30% for females by June 2020.	All schools have a specialist Youth Health Nurse in attendance to provide services across Northland. Youth Nurses are able to screen and treat Chlamydia via standing orders. Promote appropriate chlamydia self screening in 3 established school-based health centre sites for Years 11-13 utilising the Drop Box method piloted in 2018. 3 GP clinic or Community Pharmacy sites will pilot the free drop box self swab for Youth aged up to 25 yrs old. Deliver a youth community awareness campaign targeted for Māori particularly Male re: Chlamydia, condom use and getting checked 2 weeks post a new partner with a view to increase opportunities for screening/treatment in both school based health clinics, youth health hubs, general practice and community pharmacy. This will include opportunistic screening at youth community events. Utilise Northland's youth health database to monitor rates of chlamydia diagnosis and subsequent treatment and follow-up screening 3mths post treatment by ethnicity. *Northland DHB Sexual health Service Redesign currently awaiting business case approval to make free sexual health visits more accessible across Northland via GPSI and Nurse led services.*	Increase overall school based clinic screening of Chlamydia by 5% School based screening of the 3 schools and community clinics/pharmacies screening where the drop box promotion occurs youth screening is increased by 20% in males and 10% in females 5% increase in Chlamydia testing coverage for Māori males based on ESR national data to 10% Total Māori positive chlamydia rates reduce to <20% based on national ESR data. Incremental reduction in overall incidence of Chlamydia for Māori aged 15-24 within Northland to achieve equitable incidence with non-Māori by 2025

Babies Living in Smoke Free Homes SLM Plan for 2019/2020

Babies living in Smoke free homes at 6 weeks post-natal – by Ethnicity & Quintile - Northland DHB of Domicile, November 2018 – data source: NSFL website





Note: From January 2019 a new data standard has been rolled out nationally. Therefore, there will be no data available for this SLM for the first 6 months. The data pictured above is taken from the NSFL website that is based on the cohort of babies from Jan-Jun 2018. The milestone for the 2019/20 plan is based on this available data.

Utilising the previous data available from the well child tamariki ora database Nov 2018, in Te Tai Tokerau we have 24% of Māori pēpi living in smokefree households in comparison to 62% of Others. Overall less than half of Te Tai Tokerau pēpi population live in a smokefree household.

We can also see that smoking is more prevalent in the lower decile areas in Te Tai Tokerau. This information is not new for Te Tai Tokerau and much effort continues to reduce the number of smokers in the region.

In comparison to the data set used for the 2018/19 plan we are unable to see the number of 'unknown' – this indicates the percentage of babies where the whānau household smoking status is not recorded. We will need to be cognisant of this in the new data set and definition to ensure that whānau are being asked the questions regarding smokefree households. There have been some changes within the national databases to ensure that these sections are completed before being able to move on to the remainder of screening.

The aim for the 2019/20 plan is to increase the number of Māori pēpi living in smokefree households by 2% by June 2020. This mahi is a component of the much greater Northland Smokefree strategy.

Our actions will focus on the National Child Health Information Platform (NCHIP) database. This enables providers to view a dashboard of all the universal milestone checks that a child 0-6 years of age is entitled to receive. It will enable providers to have a view on which services are engaged with tamariki and where services may require support to engage with whānau. These activities will be guided by the Regional Working Group for NCHIP which includes a communications plan, workforce development plan and management of the enhancements required for the database.

Milestone	Activities	Contributory Measures
	Healthy Start- Babies Living in Smokefree Households will be improved	

	by these activities, and link and will benefit the outcomes for the ASH plan.	
The aim for the 2019/20 plan is to increase the number of Māori pēpi living in smokefree households by 2% by June 2020.	Implement the National Child Health Information Platform (NCHIP) database across Te Tai Tokerau. Enables providers to view a dashboard of all the universal milestone checks that a child 0-6 years of age is entitled to receive. It will enable providers to have a view on which services are engaged with tamariki and where services may require support to engage with whānau. Implement the Child Health Integration Hub to support access of priority tamariki and whānau into universal services. This will include a triaged assessment approach inclusive of an intersectoral taskforce for priority children 0-6 years. E.g. "children lost to services/recurrent DNAs, children with high ED utilisation, ASH readmissions, children in Oranga Tamariki	10% increase number of Māori infants enrolled in a Primary Health Organisation by three months from 77% to 87%. (Newborns Born in the Following Period: 19 May 2018 to 19 Aug 2018. Q1 2018) 10 % increase number of Māori babies receiving the first three core checks 1-3 from 55% in Nov 2018 to 65% by June 2020. Hospital admissions for children aged five years with a primary diagnosis of asthma
Reduce the number of 'smoking status unknown' for Māori babies	Improve the quality of data collection on smoking status of households for infants at 6 weeks of age by: Support LMCs and Well Child/Tamariki Ora providers to improve the quality of their data collection through face to face contact and education by the Smokefree Kaitiaki roles. Utilising the Smokefree Kaitiaki role support to LMCs and Well Child/Tamariki Ora providers to increase of the number of referrals for their clients to quit smoking services	Data quality and collection of smoking status for households of infants at 6 weeks of age is improved. Enrolments of Māori and especially hapu mama to Stop Smoking Service increase.