NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

ANNUAL PLAN
2020/21

incorporating

STATEMENT OF PERFORMANCE EXPECTATIONS 2020/21

and

STATEMENT OF INTENT 2020/21-2023/24

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

2128/20
PLA 1

Hon Chris Hipkins

MP for Remutaka

Minister of Education
Minister of Health
Minister of State Services

Leader of the House
Minister Responsible for Ministerial Services

25 September 2020

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

Dear Harry

Northland District Health Board 2020/21 Annual Plan

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

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

I encourage you to continue discussions with your fellow Chairs about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. I particularly encourage you to ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path.

The Ministry will shortly engage with you on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. I encourage you to accept offers from the Ministry to utilise this funding.

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

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

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

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

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

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

cc Nick Chamberlain
Chief Executive
Northland District Health Board

Contents

1 Overview of Strategic Priorities

1.1 Strategic Intentions, Priorities, Outcomes

Vision and mission

Our responsibility to the people of Northland is to ensure providing patient and whānau centred care is at the heart of everything we do.

Our success is measured through our vision: "A Healthier Northland / He Hauora Mo Te Tai Tokerau"

Guiding us to achieve this is our Organisation Values, the Quadruple Aim, and working in partnership with Māori to:

- improve population health and reduce inequities
- improve the patient experience
- improve the employee 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.

We believe everyone has the right to the highest attainable standard of physical and mental health. With this belief comes our responsibility to ensure that all our services, facilities, and workforce are accessible, acceptable and sufficient.

Our Annual Plan sets out key actions and initiatives we have defined necessary to improve our physical and mental health services to increase health equity for groups who experience poor health and social outcomes, in particular, our Māori and Pacific peoples and disabled people.

A wide range of factors affects the wellbeing of our population. Our rurality and poverty challenge us, but accessibility means far more than just a physical distance. We must provide access to health facilities, goods and services without discrimination, and it must be affordable for all.

Our Plan reflects a number of the key findings of the Health & Disability System Review. We are also continuing to challenge the way we work harnessing positive service developments and innovations highlighted through the ongoing COVID-19 response.

Strategic priorities

Our strategy *Northland Health 2040* will be published later this year and will set out a roadmap for strategic priorities and future planning and work towards the optimum arrangement for the most effective and efficient delivery of health services. It is a five year strategy with a 20 year horizon which will guide us in eliminating health inequities over the next two decades; 2040 has been chosen because it is the two hundredth anniversary of Te Tiriti O Waitangi and because it represents the date that babies born this year will reach maturity.

We believe that the strategy needs to be transformative. Disruptive and profound changes are required if we are going to eliminate inequities. The strategy will align with the Health and Disability System Review, which will of course be a key foundation. Although it is Northland DHB's strategy it will cover the whole health sector and broader inter-sectoral relationships, partly in recognition that that is our legislative responsibility, but also because the goal can only be achieved if the strategy has such a wide reach.

So far we have completed an extensive engagement process that has involved online feedback, community hui and clinical hui, and have prepared a draft summary of what we were told. We are currently planning a process for developing the strategy's high-level themes, which will involve ELT, Iwi, senior clinical staff and others. The intention is that each theme will be supported by strategic 'direction of travel' statements that can be developed into five-year and annual plans.

Immediate Priorities

Our priorities for the next twelve months remain focused on equity and accessibility and include increased investment into Māori Health, Planned Care, Diabetes and our vulnerable services. We are also focused on shifting more services from hospital to community services, enabling our non SMO workforce, kaiāwhina, working at a top of scope strategy, and building on the positive service developments and virtual care models that emerged during the COVID-19 response.

Key investment priorities for FY20/21 are: Māori Health Equity, Shifting more services to the community, Diabetes, Child and Maternal Health, Renal, Increased theatre capacity, Vulnerable services – including Ophthalmology, ED, Labs, and rural services, Safer after hours care, New graduate nurses and CCDM.

Working with iwi, hapū, whānau and Māori communities

Northland DHB's *Te Taitokerau Māori Health Priorities* states that "eliminating health inequalities is the responsibility of all providers and all health professionals working in the health sector. Māori health improvement requires a whole of system commitment if we are to see a change in health outcomes for Māori whānau." The breadth of this approach is captured in the diagram.

A key part of this all-encompassing approach is partnering, working and co-designing with iwi, hapū, whānau and Māori communities. This is expressed in several actions in 2.1 He Korowai Oranga that have arisen out of the above-mentioned plan.

Ensuring out-year planning is robust and supports system sustainability

Northland DHB is working alongside the Ministry to take a longer-term approach to planning with the view to better understand the future fiscal risk for the organisation. This process includes undertaking a more comprehensive approach with medium-term financial planning including such focus areas of organisational workforce and savings initiatives.

To support better out-year planning, Northland DHB is going to implement new financial planning software to replace the current spreadsheet based models. This software enables an improved financial planning process and enables more robust decision making on areas including new initiatives, service delivery and high level strategic planning.

Commitments

Northland DHB has a commitment to giving effect to the articles o Te Tiriti o Waitangi. This policy will underpin the vision, policies, structures and overall operations of Northland DHB. This will be necessary as the DHB:

- raises its responsibility to engage in genuine partnership with its Iwi/Māori stakeholders demonstrating good faith cooperation and sharing in decision making.
- actively protects te tino rangiratanga and taonga of Iwi/Māori in self-determination over their development, environment and lands, territories and resources.
- removes Māori health inequities so that whānau can participate in community life as equals to enjoy non-discrimination, redress, and special measures.

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 Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan, namely:

- Pacific wellbeing
- respectful relationships
- valuing family
- high-quality care.

1.2 Message from the Chair and Chief Executive

Our greatest challenge and our highest priority is the relentless pursuit of equity. Northland DHB is committed to ensuring equity of access, experience and outcomes of those populations that need our support the most. This is particularly so for Māori in Northland to recognise their status as Tangata Whenua. This commitment to eliminating inequity should be read in conjunction with our overall approach to achieving optimal health and wellbeing for all Northlanders. Northland District Health Board will continue to improve the delivery of services and the wellbeing of our population during 2020/21 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 outcomes of the NZ Health and Disability Review.

The Board maintained a balanced financial position from 2003 till 2017/18 when we had a deficit budget for the first time. Fluctuations in Population Based Funding (PBF) and DHB funding caps have meant that we have had three years of increasing financial deficits. Despite significant capping of $22m for Northland again this year, the higher amount of national funding, and use of updated census 2018 figures has meant that we have managed to create a break-even budget this year based on new revenue of over $56m. As is usual for Northland DHB, last year we again met our operational budgeted deficit of $12.8m excluding the impact of the Holidays Act changes and Covid-19 and we will endeavour to do this again with our break-even budget.

Northland DHB welcomes the national Health and Disability System Review and its recommendations. We fully support the transformative approach of the review which we believe is essential if the health sector is going to meet the challenges facing it. Northland has the perfect storm of demographic factors including being in the top one to three DHBs in terms of ageing population (over 65), rurality, percentage Māori, poverty and population growth. These challenges can also be viewed as opportunities and our Annual Plan demonstrates some of the innovation we intend to implement this year, much of which is aligned with the Review.

We are developing a Northland Health Strategy 2040 which will also take a transformative, and in some cases disruptive approach. The vision that by 2040 (the 200th anniversary of Te Tiriti) a baby born in 2020, by the age of 20 will have equal health outcomes and opportunities irrespective of their ethnicity or where they live. We need radical change if we are to 'turn the curve', and that needs to happen both within the health sector where we directly influence 20 percent of health, and through upstream and health promotion initiatives where we can influence the 30 percent related to healthy lifestyle. However, because forty percent of health is determined by socioeconomic factors, we must partner and work more effectively with iwi and other inter-sectoral agencies as well. The Strategy will be aligned with the Health and Disability System review but also reflect the views of our communities and iwi as well as our community providers and hospital clinicians. The need for

profound change has been endorsed by clear messages from many submissions and numerous hui held over the past year or so.

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 of over $10m are factored into the plan from our own initiatives, procurement and supply chain savings. We are also committed to an ongoing '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 are investing more in Māori health, we are developing new hospital navigator roles and will work with our Māori Providers to ensure we jointly commission the services most suited to our Whānau's needs. We are also committed to eliminating all forms of racism within the services we provide and fund as well as strengthening our relationships (based on Te Tiriti articles) at all levels within our organisation.

More than 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 DHB 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 the support of our National DHB Public Health Advocacy function. This latter approach will also extend to alcohol and we intend to work with all DHBs on this over the next year. Demographic change, immigration and obesity are driving significant growth in demand.

The next phase of the development of Primary Care and the functions of Mahitahi Hauora, our PHO, will be explored over the next few months, taking into account the recommendations from the Health and Disability System Review. How we can achieve greater integration of General Practice, Māori Provider and DHB Community services, as well as joint decision-making and commissioning is being explored. Northland has a great opportunity to front-foot the Review and pilot some of the recommended changes.

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) so that we improve patient experience, health outcomes and system efficiencies.

The Neighbourhood Healthcare Homes Project provided many General Practices with processes such as Clinical Triage and the use of Telehealth to help deal with the challenges of COVID-19. The broader concept of a suite of locality based services which are provided to a network of General Practices is also completely consistent with the Health and Disability System Review and we will be looking at how aspects of the NHH project are adopted by all practices.

The Annual Plan is closely aligned with the Northern Region Long Term Health Plan (an evolution of the Northern Region 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 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, and are planning a significant expansion of our stroke unit. We are also rapidly expanding Te Tumu Waiora and have already appointed all of our funded HIP and Health coaching roles.

Northland DHB works very closely with our intersectoral partners to help improve socioeconomic outcomes for Northlanders, and we will continue our membership of the Northland Intersectoral Forum. Northland DHB's CEO is Chair of the Social Wellbeing Governance Group which is working on a number of social sector cross-agency priorities. During COVID-19 we worked very

closely together and had a significant work programme and weekly meetings to ensure all social agencies and councils had a joined up response with clear accountabilities.

Northland DHB has received a letter from the Capital Investment Committee stating they are recommending to the Ministry of Health that we are supported to continue to detailed design with our Whangarei Hospital Business case. We have strong support from our Northern Region partners and we need to make rapid progress on this as various reports have confirmed that our hospital is either the worst or one of the worst in NZ, and that there are significant health and safety and clinical risks that are no longer able to be mitigated. This combined with the high and complex needs of our population and communities make the Whangarei Hospital rebuild an extremely high priority.

We have multiple smaller building projects underway in Whangarei to help us reinvest in a fit-for-purpose 2040 Health delivery framework. Following the opening of our new Endoscopy Unit during lock-down, we will complete the two new Operating Theatres and Cardiac Catheter Laboratory before the end of this financial year. We have also received funding to fit out level 2 of Te Kotuku, our Maternity Unit building, and also build a lift and third floor to build a new Laboratory. Over the next couple of years we will be moving our Mental Health and Addiction Services into a single building in central Whangarei which will support a new model of care.

Design for Bay of Islands Hospital stage 2 which will include General Practice, Outpatients, and Renal Services will commence this year and remedial work will also occur at Kaitaia Hospital.

In March 2020 our world and Northland DHB changed forever. Many of the positive changes that came out of COVID-19 – the use of Telehealth and electronic ordering/ prescribing, strengthened relationships with Iwi, Māori Providers, community groups and Inter-agency leaders; clearer communication with the Ministry of Health and our stakeholders and rapid decision making – must continue and we are helping to embed these within the whole health and social sector. We are committed to ongoing testing and contact tracing capability, maintaining border (especially maritime) security as well as contingency planning for community transmission. We must continue to protect our most vulnerable, particularly those in Aged care facilities and rural and remote communities.

1.3 Signature page

Hon. Chris Hipkins
Minister of Health

Harry Burkhardt
Chair
Northland District Health Board

Nicole Anderson
Chair
Finance, Risk and Assurance Committee
Northland District Health Board

Dr Nick Chamberlain
Chief Executive
Northland District Health Board

2 Delivering on Priorities

2.1 He Korowai Oranga

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

2.1.1 Engagement and obligations as a Treaty partner

DHB activity	Milestone	Measure
1 *Northern Region Iwi-DHB Partnership.* Consolidate iwi and DHB partnership agreement between Te Kahu O Taonui and Northland, Auckland and Waitemata District Health Boards. ***EOA***	Memorandum of Understanding agreed between partners by Q2 2020/21 Work plan will be ratified by Q2 and will include internal and external KPIs for priorities. Defined monitoring and accountability processes established.	100% of work streams established by the partnership will include measurable data that evidences achievement of equity for Māori Health Outcomes. 100% of appointments of District Health Boards Chairpersons will have been ratified by the partnership. 5% growth in Māori Health outcomes investment across all Northland DHB services.
2 *Te Hiku Social Accord.* Establish a health system working group to support improvement for whānau, hapū and iwi living in Te Hiku. ***EOA***	Sign off on a set of shared Terms of Reference by Q. Health profile of Te Hiku rohe agreed by Oct 2020. Whānau will be engaged to inform an implementation plan by Q2 2020/21.A SMART implementation plan agreed by the Accord will be established by Q3.	Services identified by the plan will cover at least 85% of whānau living in Te Hiku resulting in improved service delivery.
3 *Māori Health Provider* Strategic *Relationship.* Initiate a strategic focus group between Māori Health Providers and primary care to influence district-wider planning and decision making. ***EOA***	Joint working group and ToR approved Q2 Agree to a prioritisation framework and work plan by Q3.	A minimum of 75% of Tai Tokerau's Māori Health Providers will attend at least four hui that establishes the accountability and Prioritisation framework.

2.1.2 Accelerate the spread and delivery of Kaupapa Māori services

DHB activity	Milestone	Measure
1 *Service design with Māori communities.* Implement and operationalise the work plan established from the Strategic Māori Health Provider's hui across four priority locations. (See action above). ***EOA***	Whānau forums are established to work with NDHB planning and to monitor the achievement of priorities and performance for four localities by Q3. Development of model of care confirmed Q2. Trial site identified and model tested Q3. New service model confirmed and ready for roll out in July 2021 by Mar 2021.	New models of care that are informed by whānau and Māori Health Providers will be rolled out across four priority localities.

2.1.3 Shifting cultural and social norms

DHB activity	Milestone	Measure
1 *Implement Position Statement on Te Tiriti O Waitangi and Māori health equity and equity to the general population.* Te Tiriti O Waitangi will be reflected through all service planning and developmenti. ***EOA***	A policy statement adopted by the Board with clear expectations for the CE and Executive Leadership Team by Q1. Māori health equity tool is updated and used in prioritisation planning and project workstreams. Māori Quality Framework and system audit tool is designed and implemented by Q2. Quarterly quality audits of policy. Reporting made available to DHB ELT at least quarterly with a system dashboard that includes baseline and performance.	75% of NDHB policies will be reviewed and aligned to include equity requirements by Q3 2020/21. 100% of NDHB new entrants employees will receive a refreshed Te Tiriti training programme by Q4 2020/21.

2.1.4 Reducing health inequities for Māori

DHB activity	Milestone	Measure
1 *Improved Māori Whānau Experience of Care.* Establish a Māori Clinical Governance Board to provide improved whānau and patient experience and equitable outcomes for Māori within the health system.	Scope of governance board – including remit, reach over system and representation agreed by Q1. Membership and Terms of Reference, including referral process, monitoring and CQI processes agreed by Q2. Governance Board established and operational, with formal reporting and accountability lines in place by Q3.	At least two meetings of the new board operating within the agreed scope to be held by Q2 2020/21.
2 *Using system data to provide transparent progress of*	Starting with Child and Maternal Health, an equity Dashboard will be	Three NDHB directorates will be fully using an

DHB activity	Milestone	Measure
DHB directorates progress to achieving health equity for Māori. Equity for Māori will be monitored via system information via NDHB Directorates through use of equity dashboards, which will inform models of measurement and accountability to achieving equity.	set up for key indicators by Q2 2020/21. From Q3 Child and Maternal Health will provide reporting against the dashboard with actions focused on achieving equity. Using the Child and Maternal Health Dashboard approach as a vanguard, an equity dashboard will be established in another service by Q. Set stretching targets for agreed KPIs within in each service for improved performance and achieving health equity gains for Māori by Q2 for Child and Maternal Health, and Q4 for one other directorate.	equity dashboard with focus on achieving equity of outcomes for Māori by Q4 2020/21.
3 *Maximising health gain and quality of life for Māori through prioritizing resources.* Develop service based approaches to prioritise access to Māori for components of the Planned Care initiative.	Impact assess DHB provided services where maximum health gain for Māori can be achieved through prioritizing access to Planned Care initiatives by Q2. Establish relevant protocols, pathways and programmes to deliver priority access to Planned Care initiatives within four identified services by Q3. Embed in the interface between primary and secondary care services the necessary processes to deliver priority to Māori for the selected services by Q4. Establish baseline measures and set stretching targets for agreed KPIs within each planned care initiative by Q3.	Measurable health equity gain for Māori in baseline performance of access to Planned Care initiatives.
4 *Rongoā Māori Service Co-design.* Agree a business case to fund access to Rongoā Māori Services across Tai Tokerau. ***EOA***	Co-designed service of value to Māori whānau across the DHB's service boundaries by Q2. Business case completed to NDHB Board for approval to invest in Rongoā services in Tai Tokerau presented to NDHB Board by Q3.	All Māori who wish to have access to rongoā services and practitioners funded by the DHB system in 2021/22 will have the opportunity to do so.
5 *Creating equity in the Northland Health Workforce.* Establish a workforce employee dashboard to be used by services and managers with clear expectations and actions that enable the DHB to achieve the Affirmative Workforce Action Plan.	NDHB Recruitment team to be appointed as guardians of Workforce Employee Dashboards, in partnership with the Māori Health Directorate by Q1. Baseline measures for workforce composition established within services and directorates by Q1. Recruitment plans and processes to achieve Workforce Equity in Northland established by services and reported to HR by Q2.	100% of Northland DHB's directorates have committed to the Affirmative Workforce Action Plan by Q2 2020/21. 100% of Māori candidates are offered interviews. Net gain in Māori workforce of 10% by Q4 2020/21.

2.1.5 Strengthening system settings

DHB activity	Milestone	Measure
1 *Commissioning and Service Review*. Implement a Commissioning Framework which enables transparent use of system and performance data to inform better insights into how and where effective health equity gain for Māori is achieved which will inform future purchasing decisions for Māori Health. ***EOA***	Build upon Māori Health Community review to co-design a new way to deliver Māori health services across settings completed by Q2. Complete 'Commissioning for Outcomes and Population Performance System' work by Q2. Baseline measures established with reporting requirements focused on improving health equity for Māori by Q3. Services purchased under the new framework by Q3.	Measurable achievement of Māori health quality of life measures (to be set during Q3 2020/21 as part of the implementation).

2.2 Improving sustainability

These linkages 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 improved quality of life	Support healthier, safer and more connected communities

2.2.1 Improved out-year planning processes

DHB activity	Milestone	Measure
Workforce		
1 Develop and launch: • the new Northland Health Strategy identifying new and evolving models of care and workforce needs, which in turn will direct the development of agency specific shorter term workforce development plans • the Clinical Services Plan, which guides the development of Northland DHB's clinical services for the next 20 years, with the ultimate goal of improving Northlanders' health outcomes; it covers the types of treatment provided and who is responsible for them, as well as where and when treatment is delivered.	Q1.	
2 Contingent on national developments deploy a local workforce survey capturing roles and demographics across all health providers in Northland.	Q2.	
3 Establish an annual management review and report on NDHB Workforce Planning practices.	Q1.	
Financials		
1 Implementation of financial planning software to support improved multiyear budgeting & forecasting.	Q2.	
2 Completion of the Northland DHB Asset Management Plan.	Q2.	

2.2.2 Savings plans – in-year gains

DHB activity	Milestone	Measure
The Financial Sustainability plan for 2020/21 is committed to delivering $10.6m in savings within the year. The five key areas of focus for Northland DHB continue to be:	Q1: programme structure finalised and opportunities prioritised. Q4: benefits will be realised over the course of the year.	Positive impact versus budget, measured by comparing actual expenses / income with the budget for the corresponding period.
1 Clinical Stewardship. This programme is led by clinicians to consider Value Based Healthcare, Choosing Wisely, Best Value Process & Procurement and Commissioning for outcomes. Expected savings range $0.5M – $1M.		
2 National initiatives. We continue to actively engage with NZ Health Partnerships, MBIE & PHARMAC to maximise procurement opportunities for Northland. Expected savings range $1M - $2M.		
3 Regional initiatives. Together with the three Auckland DHBs, Northland runs two shared service agencies, healthAlliance & HealthSource for the delivery of information technology, finance, procurement & supply chain activity. Expected savings range $1.5 - $2M.		
4 Local initiatives. Various productivity and cost savings initiatives which include providing hospital services closer to home, releasing time to care, productivity and equipment & fleet management. Expected savings range $4 - $5M.		
5 Revenue collection. Ensuring that revenue is collected for all work performed, for example ACC revenue. Expected savings range $1M - $2M.		

2.2.3 Savings plans – out-year gains

DHB activity	Milestone	Measure
The Financial Sustainability plan for out-years is committed to delivering $10.6m in savings within each year. The five key areas of focus for Northland DHB continue to be:		
1 Clinical Stewardship programme. This programme is led by clinicians to consider Value Based Healthcare, Choosing Wisely, Best Value Process & Procurement and Commissioning for outcomes. Expected savings range $0.5M – $1M.	June 2022.	Positive impact vs forecast/budgeted spend for the corresponding period.
2 National initiatives. We continue to actively engage with NZ Health Partnerships, MBIE & PHARMAC to maximise procurement opportunities for Northland. Expected savings range $1M - $2M.		
3 Regional initiatives. Together with the three Auckland DHBs, Northland runs two shared service agencies, healthAlliance & HealthSource for the delivery of information technology, finance, procurement & supply chain activity. Expected savings range $1.5 - $2M.		
4 Local initiatives. Various productivity and cost savings initiatives which include providing hospital services closer to home, releasing time to care, productivity and equipment & fleet management. Expected savings range $4 - $5M.		
5 Revenue collection. Ensuring that revenue is collected for all work performed, for example ACC revenue. Expected savings range $1M - $2M.		

2.2.4 Working with sector partners to support sustainable system improvements

DHB activity	Milestone	Measure
1 Healthcare Homes. Partner with Mahitahi Hauora to implement the virtual care components of the Healthcare Home Collaborative in practices serving our most vulnerable and rural populations – as per action 3 in 2.7.1 Primary health care integration:	As specified in 2.7.1 Primary care integration.	

DHB activity	Milestone	Measure
2 Diabetes. Four actions are listed under 2.7.3 Long term conditions including diabetes, all of which involve working with sector partners, especially Mahitahi Hauora and general practice.	As specified in under 2.7.3 Long term conditions including diabetes.	
3 Strategy. Complete the Strategy Northland Health 2040(as described in The optimum arrangement for the most effective and efficient delivery of health services under 1.1 Strategic Intentions, Priorities, Outcomes). This involves the following steps during 2020/21:	As specified in 1.1 Strategic Intentions, Priorities, Outcomes.	
Based on engagement feedback, write up Insights document, develop themes and strategic direction statements with ELT, Board, sector partners.	Sep 2020.	
Board adoption and approval.	Oct 2020.	
Publish the final Strategy.	Dec 2020.	
Embark on developing strategic measures so progress on the themes and strategic direction statements can be monitored.	From Jan 2021.	

2.3 Improving child wellbeing

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	Make New Zealand the best place in the world to be a child

2.3.1 Maternity and Midwifery workforce

Action 2 under 2.3.2 Maternity and early years also supports this priority.

DHB activity	Milestone	Measure
System outcome: we have health equity for Māori and other groups.		
1 Improve the experience and outcomes of hapū mama, pēpē and whānau accessing maternity services in Northland.	Delivery of cultural competency training Q4. Establish a suite of maternity outcomes for hapū Mama and pēpē with Maternity specific outcomes identified and baseline data established Q2. Maternity dashboard modified to specifically identify outcomes of Māori women and babies Q4. Establish funding for co-payment for private scans for hapū mama who are financially disadvantaged Q1. Educate all LMCs on updated national ultrasound guideline. Establish specialty Diabetes Resource Midwife positions in primary birthing units with a focus on improving access to specialist care Q4.	70% employed staff complete all components of Te Whakaruruhau programme. 70% employed staff complete equity training. Increased number of scans performed by private providers and funded by the DHB for Māori wāhine. Reduced waiting list for scans for pregnant women throughout Northland reported quarterly. Record the number of dating scans performed.
3 Establish formal consultation mechanisms with Te Kahu Wāhine in order that whānau Māori advise NDHB leadership on the needs of whānau/ hapū mama in the maternity space.	Formal contract with Te Kahu Wāhine is established to support the provision of advice to the DHB Q2. Regular meetings scheduled with Te Kahu Wāhine Q4. Contract developed.	Four meetings per year are held.
4 Utilisation of face to face Zoom/ telehealth for specialists/ LMC/ GP consultation with pregnant women unable to attend all clinic-based appointments.	All NDHB clinical staff and key midwifery roles have Zoom access and are confident initiating and joining meetings Q2.	Increased virtual consults by clinician and specialty roles for pregnant women in their own home, prioritising Māori women and women living in quintile 4 and 5 communities.

DHB activity	Milestone	Measure
5 Increase uptake of pertussis vaccination and flu vaccination for pregnant Māori women, core midwives and LMCs.	Awareness campaign for staff and LMCs Q1. Targets for vaccination of core midwifery staff Q1. Community awareness raising campaign prioritising whānau Māori Q1. Prioritised pharmacies are able to deliver pertussis and flu vaccine to pregnant Māori women Q1. Midwife vaccinators located at each NDHB maternity facility Q2.	# vaccinators located in each maternity units. # vaccinations given in maternity units. # vaccinations given in pharmacies.
6 Delivering Better Public Services Result. Increase registration with LMC in first trimester – focus on equity for hapū mama.	Joint discussions with key stakeholders to map out current processes, and develop an agreed pathway that enables facilitated and early engagement with a LMC at confirmation of pregnancy for prioritised women Q2. Maternity outcomes suite is agreed and data reported reflects ethnicity of birthing women Q1. Improve NDHB ethnicity data collection for registrations with LMC Q1-4.	60% pregnant Māori women registered with a LMC by 13 weeks.
7 *Midwifery Workforce.* In collaboration with AUT increase the sustainability of the Midwifery workforce in Northland, with a particular focus on meeting Māori needs and those living in rural areas.	Retention of new graduate midwives by providing localised support in addition to participation in the national Midwifery First Year of Practice programme. Q1-4. Orientation meeting for all new graduate LMC midwives to inform of relevant DHB administrative requirements. Q1. Prioritise rural schools and rangatahi Māori to promote midwifery as a career choice Q1. Include Māori Women's Welfare League in recruitment activities by attendance at a League meeting by NDHB, AUT, Tekahu Wāhine representatives for the purposes of information exchange Q4. Up to two graduates financially supported to work in the secondary maternity service in Whangarei Q1-4.	Eight student midwives recruited into first year of programme with a stated commitment by AUT to prioritise applicants who are Māori. Increased retention rates of LMC. Improved access to LMC across Kaipara.

2.3.2 Maternity and early years

DHB activity	Milestone	Measure
System outcome: we have health equity for Māori and other groups.		
1 Build upon the existing mechanisms that promote child	Incorporate Te Whare Ora Tangata (Maternal and infant care	Increase the percentage of Māori infants fully

DHB activity	Milestone	Measure
health to establish an inter-sectorial forum that advances health outcomes for tamariki Māori and children across Northland.	connection forum) into Te Māhuri to ensure improved visibility and connection to parenting support programmes, universal child health services for mama/ pēpē post birth Q1. Establishment of Level 2 Te Māhuri Connection Service virtual forum with Well Child Tamariki Ora Providers to mitigate issues of enrolment before three months of age. Priority group are pepē Māori and Pasifika. Q1. Build formative evaluation into the new model and review Q2&4. Whānau Tahi platform operational (testing completed) Q1. Establish baseline measures across key indicators for Te Māhuri Q1.	enrolled with GP at 3/12 from 66% in Q2 2018 to 71% by Q4 2020. Increase the percentage of Māori babies receiving the first core check before 50 days from 69% in Jul-Dec 2018 to 75% by July-Dec 2020. Increase percentage of tamariki Māori enrolled and receiving first assessment with the oral health service from 77% in 2017 to 85% in 2020/21. (NCHIP will provide access reporting about enrolment and attendance with oral health service by 1 year of age as a milestone). # pēpē in Te Māhuri who have a current enrolment with a lead professional/provider.
2 Provide system leadership to provide resourcing, guidance and establishing operational networks that can enhance the outcomes from the first 1000 days strategies across providers. This includes continuing with SUDI actions: • provision of safe sleep spaces and distribution hubs • weaving wānanga • workforce development, with a focus on ECEs and WCTO providers and Smokefree Hapū Mama programme as resource enables, and seeking every opportunity to incorporate in BAU where possible.	Work with partners to establish agreement with community providers and schedule of wānanga established Q2. Graduation of programme facilitators – (re-scheduled for Level 1 Covid-19 response) Q2. Roll out safe sleep spaces and expand distribution hubs and increase opportunities to incorporate BAU Q1-4. Monthly meeting of Safe Sleep Champions network continues – minutes accurately reflect discussion and action points. Q1-4. Bilingual resource developed and distributed with training programme for safe sleep messaging in Kohanga Reo and ECEs Q3. Early Notification of Death project established Q2. Three step project for Early Death Notification completed. Q4.	Increase # providers facilitating wānanga. # Hine Kōpū and Whaia te Ora wānanga held each quarter. Increase # safe sleep champion meetings with minutes and actions reviewed. Increase the# providers in distribution network for safe sleep spaces. Increase the # kohanga Reo and ECEs with safe sleep education resources.
3 Address ASH for tamariki Māori: see Appendix 2 System Level Measures Improvement Plan 2020/21.		
4 Improve the capacity and capability of Child Development Services to enable better outcomes for tamariki and whānau through enhanced workforce skills.	Continuum of care is mapped, issues/ gaps identified and action plan for mitigation agreed. Q1. Data collected about patient assessment and treatment is accurate and consistently collected across allied health providers in the CDS Q2. Service delivery prioritizes tamariki Māori and children domiciled outside of Whangarei Q1-4.	# referred children who are new to CDS and receiving CDS. All children are seen for initial assessment within 4 months of referral being received and accepted. Waiting times are reduced and fit within the target timeframe Q4. 75% of clinical staff have completed foundation

DHB activity	Milestone	Measure
	Recruitment of allied health staff as annual tranches of funding occur Q4. Implement the Calderdale framework across allied health within the context of improving access to services for tamariki.	training for the Calderdale Framework. 3 facilitators trained at Child Health Centre.
5 Undertake a review and co-design a new Model of Care for outpatient service delivery within Child Health Centre to ensure that models are inclusive for Māori whānau.	Review of service and recommendations completed Q1. Work with Mahitahi Hauora "What Matters to Whānau" leaders to facilitate consumer engagement in new MoC Q1. Link with Mahitahi locality team to prioritise tamariki Māori access to outpatients clinic in the Mid North Q1.	5% increase in tamariki Māori attending their outpatient appointments by domicile clinic: 2019 % DNAs for tamariki Māori Kaitaia 20% Kawakawa 14% Kaikohe 31% Dargaville 7% Whangarei 25%

2.3.3 Immunisation

DHB activity	Milestone	Measure
System outcome: we have health equity for Māori and other groups.		
1 Improve the access of immunisations to whānau across Northland.	Undertake discussion with pharmacies to provide funded pertussis vaccine for pregnant women in prioritised communities Q1. Pharmacies in prioritised communities agree to participate Q1. Funding mechanism established via Primary Options Acute Demand Management Services (POADMS) Q1. Necessary training for pharmacists completed Q2. Community awareness campaign undertaken Q2. Expansion of immunisation provision by Māori provider nursing services via fee-for-service model. Q1. Facilitation/ coordination of vaccinator training for Māori provider workforce. Q2. Contracts for fee-for-service model established and signed off by both provider and funder Q2.	# pertussis vaccinations for pregnant women given at participating pharmacies. # of current non-Medical Vaccinators in each Māori health provider. # of tamariki Māori immunised via fee for service.
2 Develop and align public health messaging that meets the needs of Māori on the benefits of immunisation by utilising the whakatauki as a foundation.	Māori leadership at governance level for immunisation programme Q1. All stakeholders engaged and participating in agreed str.tegy. Q1. Media collateral developed and distributed Q2 Evaluate effectiveness utilising a range of approaches, parent focus groups and whānau attending w1ananga, providers of universal child health services.Q1-4.	# of Māori whānau completing surveys and/or participating in wānanga discussions – collated feedback. RBA methodology. Immunisation rates for Māori infants and non-Māori infants at 6 months.

2.3.4 School-Based Health Services

DHB activity	Milestone	Measure
System outcome: we have health equity for Māori and other groups.		
1 Expand options for student access to contraception including Long Acting Reversible Contraceptives by enabling school based health service delivery.	With support from the Kaiāwhina team engage with Kura, Alt Ed and Teen Parent Units to socialise service and facilitate student access Q1. Increase nurse confidence in insertion of LARC – work with primary	# students by age, quintile and ethnicity and domicile: # students accessing school-based contraception

DHB activity	Milestone	Measure
	care partners for further opportunity to observe and insert Q2. Prioritise rural schools in Quintile 4 and 5 communities to support equitable access to services for young people Q1.	consultation. # consultations for rangitahi Māori. # of Jadelle LARC insertions. # Jadelle LARC insertions for rangitahi Māori. # GPwSI consults. # GPwSI consults for rangitahi Māori.
2 Ensure all eligible students receive HEADSSS assessment.	Continue programme of "virtual" HEADSSS assessment where appropriate.Q1-4. Targeted and prioritised approach for Māori and high quintile students with face-to-face HEADSSS assessment.Q1-4. All backlog HEADSSS assessments are cleared by Q2.	# of completed HEADSSS for all eligible students. # of completed HEADSSS for eligible rangitahi Māori. # of referrals to youth school based and other primary/secondary health services post HEASSDS assessment by service type and by ethnicity. Increased number of students seen within schools each week – targets based on numbers of students yet to receive HEADSSS assessment.

2.3.5 Family violence and sexual violence

DHB activity	Milestone	Measure
System outcome: we have health equity for Māori and other groups.		
1 Participate in Te Māhuri Care Connection forum ensuring that children where there are safety concerns are included and that whānau connections to 'best-fit' community and primary care services are facilitated.	Process for sharing of information is developed and agreed Q1. Process is implemented and information is shared at the Te Māhuri Care Connection forum by Q2. Tamariki with a child protection as a result of the Te Māhuri forum have a lead professional provider Q4.	# tamariki with NCPAS alerts who are included for discussion at Te Māhuri. # tamariki with an alert who as a result of Te Māhuri have successful whānau connection to a lead professional/ provider.

2.4 Improving mental wellbeing

These linkages above apply to all priorities under 2.4

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

2.4.1 Mental health and addiction system transformation

DHB activity	Milestone	Measure
Placing people at the centre of all service planning, implementation and monitoring programmes		
1 Consumer and Family Leaders (CFLs) will be given new roles and responsibilities for leading and facilitating co-design and service user and whānau participation at service and team levels. CFLs will provide education to the clinical workforce on engaging with service users and whānau, recovery focussed practice and co-design, and participate in MHAS clinical governance to develop policy, strategy and quality development. These actions demonstrate MHAS leadership in promotion of Code of Health and Disability Services Consumers rights.	CFL pilot recovery responsiveness assessment and Planning model with 2 clinical teams using TRIP tools (Imroc) Q1.	Improved rating on TRIP scale for 3 priority action areas achieved, by Q4.
2 CFLs will support each service area to develop an improvement action plan in response to post-rotation Real Time Feedback reports.	Schedule of six service rotations in place, Q1 2020/21.	Provision of report post each rotation. Six action plans developed post rotation Q4.
3 Youth Consumer Leaders (YCL) in Whangarei CAMHS service will participate in all recruitment of the CAMHS workforce.	YCL inclusion in all CAMHS selection Q1.	100 % of recruitment and selection events including YCL on panel.
4 YCLs will review practice across all MHAS recruitment and selection, making recommendations regarding recruitment of all MHAS workforce to ensure new recruits are cognisant of the need for young people to achieve positive outcomes.	YCL review completed Q3.	Action Plan Q4.
5 MHAS will align with the 's Affirmative Action Plan and work closely with the Workforce Equity Manager.	Quarterly reporting and monitoring of attendance.	80% attendance at Affirmative Action Plan training

DHB activity	Milestone	Measure
Recruiting MHAS Managers will attend training to improve recruitment outcomes for Māori and others who experience disproportionate employment outcomes.		achieved for MHAS recruiting managers, Q4 .
6 Develop a strategy to actively reduce use of restraint in the MHAS In-patient Unit.	Development of accurate reporting mechanism, Q1. Monthly and quarterly reporting, Q2.	# restraint events. # unique service users restrained Māori and non-Māori.
Embedding a wellbeing and equity focus		
7 Grow the use and availability of Te Hikuwai Talking Therapies (THTT) across primary and community care. Te Hikuwai provides a web-based package of brief intervention self-help tools and resources developed by Te Pou which include topics such as sleep, relaxation, chronic pain and fatigue and exercise.	Complete the rollout of THTT to general practice (via PHO) in Q1. Monitor and promote the use of THTT to general practices via the PHO to increase the uptake of packages throughout 2020/21. Establish baseline performance in Q1.	Grow uptake and use of THTT across primary care quarter on quarter from Q2 onwards.
8 Improve health outcomes for people with low prevalence conditions.	Establish an inter-organisational workgroup with appropriate representation to meet a defined scope for the project by Q1. Develop a communication action plan for general practice by Q2. Implement a Physical Health KPI Policy to improve Health Assessment and Screening Initiatives by Q1. Identify workforce training that enable the achievement of the Physical Health KPIs and improved Health Assessment and Screening Initiative needs by Q2. Implement training programme from Q3.	80% of service users engaged with MHAS >12 months monitored through letters to GPs from Responsible Clinicians. % service users with completed physical health monitoring, Māori and non-Māori.
9 Extend the Individual Placement Support (IPS) model to two additional areas of Northland. IPS has already achieved positive outcomes for people with low prevalence conditions, co-existing conditions and substance misuse communities in two rural and remote areas across Northland that experience high levels of social deprivation.	Identify two areas against priority criteria of rurality and high levels of social deprivation by Q1. Successful application to Provincial Growth Fund for 8 FTE by Q2. FTE Recruitment Q3. Service start Q4.	# service users with low prevalence conditions accessing IPS service, Māori and non-Māori. # service users achieving employment, Māori and non-Māori.
10 Establish a Psychological Wellbeing Hub in partnership with NGO, iwi and youth groups to provide navigation support to the people of Tai Tokerau. The Hub will utilise Kaupapa Māori groups and link to the Kaimanaaki Programme being led by Mahitahi Hauora.	Business case for investment approved in Q1. Site goes live Q1.	Utilisation of site resources.

DHB activity	Milestone	Measure
11 *Supporting Parents Healthy Children.* The Specialist Services, NGO providers and Mahitahi Hauora will collaborate and deliver improvements across the agreed three priority areas below as developed in 2020: • workforce training • data collection and reporting • providing family and whānau friendly environments.	Whole of Northland SPHC Action Plan 2020/21 developed Q1. Quarterly progress update all providers against Northland SPHC Action plan Q2-Q4.	Review workforce training programmes and resources with Werry Centre # training workshops delivered. # providers who access SPHC training and resources. # providers able to report in compliance with national guideline. # Providers able to demonstrate family and whānau improved experience of their environments.
12 Te Tai Tokerau cross-sector, multiagency partnership forum, the Social Welfare Governance Group (SWGG) will drive transformation in line with He Ara Oranga. Partners include senior leadership from MSD, Police, NDHB, MoE, Oranga Tamariki, Far North District Council, Te Kahu o Taonui, Te Puni Kokiri, Ngāpuhi Iwi Services, Northland Regional Council, Te Hiku Iwi representative. SWGG has formed 6 sub-groups each dealing with a key priority area, one of which is the Welfare Sub-Group that holds governance for areas including Family Harm: Mental Health, Suicide, Education, Children, Psychosocial, Accommodation.	Welfare Sub-group monthly meeting.	Development of an operating model to transition CDEM groups to an expanded social sector services framework Q2. Measures to be established as part of the operating model that is developed in Q3.
Increasing access and choice of sustainable, quality, integrated services across the continuum		
13 MHAS undertakes quarterly productivity reporting as part of a continual review process. Efficiencies are identified and funding reallocated to support sustaining current service and improving outcomes. Creation of a new community pharmacist position from efficiencies achieved by reducing cost of medication.	Submission endorsement Q1. FTE recruited Q2. Service start Q2.	# education sessions provided by new position. # medication reviews reconciliation events.
14 Establish a pilot respite facility located in Kaipara rural and remote areas that uses a Kaupapa model to provide a female-only service, enabling women to remain in their own community and maintain contact with whānau and natural support networks.	Pilot evaluation Q2. Proposal for future service Q2. Ongoing investment decision made Q3.	Qualitative whānau / SU experience of service. # occupied bed nights utilised. # unique service users accessing facility, Māori and non-Māori.
15 Develop a business case to invest in enhanced Home Based Treatment services with a view to improving patient experience and reducing demand on the IPU.	Confirm the scope of the business case to include prevention of admissions, improved SU experience, improved patient flow, reduced ALOS and reduced readmissions by Q1.	Baseline measures of ALOS, occupancy, readmissions taken prior to implementation of model.

DHB activity	Milestone	Measure
	Hold co-design workshops to inform models of care and options by Q1. Complete and submit business case to NDHB executive for Q2.	# co-design workshops facilitated. # service users and whānau attending.
16 Participate in a Northland wide collaboration, with partners including Mahitahi Hauora, NGOs and Iwi to develop strategies for primary mental health and addictions initiatives in response to MoH RFPs. These include: • Integrated Primary Mental Health (Te Tumu Waiora) • Kaupapa Māori • Youth Primary Mental Health & Addiction Services • Kaupapa Māori new service.	RFPs submitted, date TBC. RFPs accepted, date TBC. Contracts completed, date TBC. Service start, date TBC.	# contacts by HIPs. # unique service users Māori and non-Māori. # Health Coach contacts. # Unique service users Māori and non-Māori.
17 Review the cost pressure contribution to NGOs (in alignment with the Northern Region agreed approach).	Annual Review Q4 2020/21	NGO `FCP allocation 2020/21.
18 Mahitahi Hauora PHE will deliver a professional development MHAS programme facilitated by a multi-agency approach to sector workforce including MSD, Youthspace, Voice and School Nurse Clinics, increasing capability in primary care and in community to strengthen and increase the focus on mental health promotion, de-stigmatisation, prevention, identification and early intervention. The programme has a specific focus on youth mental health and youth addiction. Programme will be open to 12 participants.	Q1 completion of the programme. Q3 evaluation survey.	% participants completed. Improvement in confidence and competence of primary MH.
Suicide prevention		
19 The Suicide Prevention Program Lead reports on suicide prevention (including postvention) quarterly against the Taitokerau Suicide Prevention Collabor-Action Plan. The Plan will continue to be reviewed, including working with MoH's Suicide Prevention Office to ensure alignment with Every Life Matters Strategy and Action Plan.	NDHB quarterly report to Suicide Prevention Office.	NDHB quarterly report to Suicide Prevention Office.
Workforce		
20 Utilise Matua Raki resources, online modules and the AoD Educator role to develop a workforce CEP training plan that includes specialist, NGO and primary care workers.	Workforce plan Q1.	# team trainings facilitated. # participants.

DHB activity	Milestone	Measure
21 Extend recruitment of New Graduate Nurses over and above our usual New Entry to Specialist Practice allocation, giving priority to Māori applicants in alignment with the DHB Affirmative Action Plan.	Recruitment Q3. MHAS managers KPI development.	# new graduates offered permanent contracts. # Māori nurses new to MHA workforce.
Forensics		
22 Participate in the Northern Regional approach to develop an action plan in response to the Ministry's Forensic Framework.	Participate in development of a Northern Regional approach by Q4.	Forensic Framework in place for Northland as part of the Northern Regional work.
Commitment to demonstrating quality services and positive outcomes		
23 Create an action plan to reduce rates of Māori on Compulsory Treatment Orders.	Working groups held with stakeholders to inform the action plan throughout Q1. Action plan developed by Q2.	Reduce the rate of Māori on CTO by 10% by June 2021 compared with July 2020 baseline.
24 Ensure highest levels of compliance of PRIMHD data.	Ongoing monthly review process to identify any errors and correct them Q1-Q4.	Data accuracy rate 98% or better.

2.4.2 Mental health and addictions improvement activities

DHB activity	Milestone	Measure
1 Develop new orientation resources for service users and their whānau for the MHAS In-patient Unit.	Implement a co-design process with service users and whānau on what orientation information is important when entering IPU service Q1. Develop new resources and implement across the service Q1 & Q2.	Reduced number of seclusion episodes for Māori and non-Māori: 20% reduction in average seclusions/ month calculated on a rolling 12 month basis. Baseline: average seclusions Māori and non-Māori 12 months to June 2020. Reduced average duration of seclusion episodes Māori and non-Māori: 20% reduction in average seclusion durations/ month calculated on a rolling 12 month basis. Baseline: average seclusion durations/ month Māori and non-Māori 12 months to June 2020.
2 Undertake a review of transition processes from specialist MHAS community services into primary care. This will progress the HQSC national project Connecting Care and Improving Transitions.	Percent of discharged service users returning to service within 28 days including one or more of the following criteria: (a) referred from Police or (b) Emergency Department presentation MHA related.	Create the measure baseline in Q1. Reporting against this over following quarters, expecting a reduction against baseline.

2.4.3 Addiction

DHB activity	Milestone	Measure
1 AOD national MoC TBC by MoH.	TBC.	TBC.
2 Work with Salvation Army and Ngāti Hine NGO to establish a single Point of Entry for AOD in the Mid North through a new collaborative, integrated model of triage and entry to service. This will reduce waiting times and increase capacity across the sector, and further develop productive relationships between providers.	Finalise service pathway Q2. Formalise Single Point of Entry MoU between stakeholders Q2. New model operational in Q3.	Reduced average wait time from referral to first contact, Māori and non-Māori.
3 Extend access for offenders in Department of Corrections facility in Northland to AOD psych education and level 4 treatment programmes. Working closely with DoC provision includes delivery of an 8 week education programme and follow up by Peer Workers and After Care Workers.	Delivery of enhanced 8 week programme, Q1 2020/21. Recruitment of additional Peer and After Care workers (2 FTE) Q1.	# programmes delivered annually. # attendees, Māori and non-Māori.

2.4.4 Maternal mental health services

DHB activity	Milestone	Measure
1 Establish.3 co-located triage clinics to increase responsiveness to referrals and encourage attendance for assessment. Sites chosen through identification of high % of Māori women seeking LMC services. The model of maternal infant mental health service is inclusive and whānau focussed, engagement is encouraged as part of referral and assessment processes according to women's preference and choice. The service will work to improve relationships between primary care and NGO providers to increase referral activity.	Establish three triage clinics: Whangarei, Hokianga and Kawakawa Q1. Quarterly performance report and review.	Reduced % DNA rate Māori women.
2 Enable increased access to psychology interventions in rural and remote areas of Northland for women in Maternal Mental Health (MMH) and Pregnancy and Parenting Service (PPS). The psychologist capacity will be supported by use of telehealth approach offering alternate in person face to face and video conference sessions. A psychology intern working under supervision of the psychologist will provide additional capacity.	Delivery of rural psychology sessions commencing Q1. Quarterly report.	# of psychological contacts delivered rural and remote, Māori and non-Māori compared to baseline. # of rural and remote unique clients seen compared to baselines, Māori and non-Māori. % improvement of discharge HONOS scores compared to baseline admission HONOS (Māori

DHB activity	Milestone	Measure
		and Non-Māori).
3 Deliver the Circle of Security programme.	Development of data capture and suite reporting referral activity for programmes delivered Q1. Provide referral pathways for Incredible Year Programme provider, Family Start Program (Ngāti Hine), Kaupapa Māori antenatal program, and Te Mata o Mua Q1.	# specialist CoS program sessions delivered. # unique clients accessing program, Māori and non-Māori. # referrals to early parenting support programs, Māori and non-Māori.

2.5 Improving wellbeing through prevention

These linkages above apply to all priorities under 2.5

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

2.5.1 Environmental sustainability

DHB activity	Milestone	Measure
1 Undertake an inventory of carbon emissions from NDHB activity.	Verified inventory completed by Q3.	By 2030, achieve the target of 50% reduction compared with 2016.
2 Join the EECA Energy Transition Accelerator programme to develop long term energy emission reduction roadmap.	Report with Long Term Investment Plan for building decarbonisation projects, by Q1.	Two projects scheduled for FY2020/21 from roadmap in progress for completion.
3 Submit a tender to install Solar PV equipment across Northland DHB sites and facilities.	Completed tender process resulting in Power Purchase Agreement with contractor to install solar panels. Q1-4.	PV panels on minimum of 1 facility, Q3 2020/21.
4 A building designed to the NZ Green Building Council Greenstar standard certification level 4 or 5 under construction.	Greenstar certification application submitted to the NZ Green building Council, June 2021.	One Greenstar certification application.
5 Implement two additional product stewardship programs for waste reduction across the DHB.	Plan and provide capacity for two waste reduction programmes to take place Q1.	Two additional product streams avoided from landfill. 0.5-1.0 tonne waste reduction.
6 Undertake a Telehealth and teleconference promotion campaign that raises awareness for DHB staff	Online communication presence planned and themes identified Q1. Staff engaged and attending digital campaigns Q2-4.	20% increase in Zoom meetings.
7 Publish a regional sustainable procurement policy.	Engage with regional partners and DHBs to create and consult on a policy. Q1. Published policy Q2.	Benefits as identified in the policy – including any measures as stated.
8 Implement a carbon offset programme for staff and patients that are required to undertake any air travel.	Business case completed for best methods of carbon offsets Q1. Implement a Carbon-offset for Air travel policy across the DHB operations. Q3.	# carbon credits purchased throughout 2020/21.

2.5.2 Antimicrobial resistance

DHB activity	Milestone	Measure
Primary care		
1 *Consumer education.* Implement a consumer awareness programme focussed on education of antimicrobial resistance and the importance of using antibiotics appropriately.	Review of impact / efficacy of previous consumer awareness campaigns regarding viral / bacterial infections to ensure ongoing promotions are relevant Q1. Requirements of a promotional campaign, including learning from COVID19, personal hygiene and culturally accessible messaging is established Q2. Communications plan is developed and implemented with multiple media outlets appropriate to consumer needs. Q3. Expand promotion of World Antibiotic Awareness Week Q2.	Number of providers (including general practice, pharmacy and Māori Health providers) receiving resources, tools or advice. % of sample satisfied or very satisfied with the resources, tools or advice they received. % of Māori providers who were satisfied or very satisfied with the resources, tools or advice received.
2 Provider Resources/ Education. Provide all prescribers, pharmacy, health care team members stewardship resources and prescribing guidance that is based on latest messaging and evidence for best practice.	Appropriate resources and prescribing guidance with local microbiologist approval made available to prescribers and relevant health care team member throughout 2020/21. An up to date antibiotic prescribing guideline sent to all prescribers and available on stakeholders' websites.	Review of # antibiotics dispensed per person per year per provider.
3 Infection Control/ Prevention. Improve the rate of immunisation to prevent infection with a focus on priority populations and Māori. ***EOA***	Use primary care data to proactively identify priority population groups that require immunization Q2. Establish hand hygiene protocols for general practice and community services to share with patients Q. Improve the quality and uptake of MEDINZ communications to general practice Q1.	Immunisation rates in our communities with data specific to our priority populations.
Hospital		
Routine Infection Prevention and Control surveillance activities would indicate that at least 90% of Northland's multi-drug resistant organisms (MDROs) are acquired in the community. In terms of our MDROs, clinical experience tells us that our Māori population tend to have a higher risk of MRSA, whereas our older Pākehā population residing in long term care facilities LTCFs are at higher risk of extended spectrum beta-lactamases. Northland Māori are heavily over-represented in poorer socio-economic deciles and, as a general rule, poverty predisposes to increased infectious disease. A meaningful reduction in the burden of infection in our Māori population would therefore require improvements in	the prevalent socioeconomic drivers of infection, way beyond the purview of hospital based antimicrobial stewardship. Factors that would need to be addressed include household overcrowding, housing quality, affordable electricity, and financial and food security. These will form a key focus of the Strategy Northland DHB is developing (see 2.2.4 Working with sector partners to support sustainable system improvements action 3, and *The optimum arrangement for the most effective and efficient delivery of health services* in 1.1 Strategic Intentions, Priorities, Outcomes.	
1 Collate data for conventional and Syndromic Antibiogram.	2020 data to be reported in Jan or Feb 2021.	Conventional AB: MRSA rate = 17%. ESBL rate = 10%.

DHB activity	Milestone	Measure
		Syndromic Antibiogram: no changes in species distribution or resistance, hence no change in empiric antibiotic therapy guidelines.
2 Daily AntiMicrobial Stewardship (AMS) activities, also known as Clinical Duties.	EQA.	Daily consults are documented in Excel sheets.
3 Continue to monitor antibiotic pump consumption through OPAT committee meetings (a post intervention decrease of 23%, or direct cost savings of $140,000, have been demonstrated since OPAT meetings were started).	Monitor annual data for OPAT antibiotic pump consumption, June 2020.	% decrease and direct cost savings of antibiotic pump consumption.
4 Clinical Audit (Staphylococcus aureus bacteremia outcome: 2016 – 2019).	Second phase data currently being collected (30 of 100 cases done), to be reported in Sep 2020.	Similar outcomes between IV- treated cohort and IV to oral switch (p value = 0.78).
5 COVID testing.	Biofire COVID test validated and confirmed by IANZ. Commence June 2020. Biofire Meninggo-Encepahlitis and Extended Respiratory Panel validated May 2020. In-house testing and reporting commenced June 2020.	
ARRC		
1 Establish a clinically led collaborative for selecting ,implementing, testing and monitoring anti-microbial stewardship in Aged Residential care services.	A clinical collaborative established by Q2 2020/21. Establish baseline data for reporting outcomes by Q3 2020/21. Implement evidence based changes for UTI management and prescribing by Q3.	Increase the # of ARC facilities engaged in service improvement. Improve the # UTI recorded at facility/ # recorded based on dipstix diagnosis. Decreased # antibiotic prescriptions based on dipstix diagnosis. Reduced average time between events.

2.5.3 Drinking water

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Maintain accreditation of Drinking-Water Assessors and Drinking Water Assessment	# of Drinking Water Assessor Full Time Equivalent (FTEs).	% of Drinking-Water Assessors that maintain accreditation. *Numerator:* # Drinking-Water Assessors	*Narrative reporting:* Nil.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
Unit.		that maintain accreditation *Denominator:* # Drinking-Water Assessors.	
2 Identify and investigate incidents, complaints and notifications of adverse drinking water quality (or adequacy) of networked, tankered and temporary drinking water supplies.	# of investigations related to incidents, complaints and notifications.	% of investigations undertaken as per the Drinking water legislation and guidelines.	*Narrative reporting:* Nil.
3 Undertake all duties and functions required by the Health Act 1956, including: Register drinking-water suppliers and water carriers as required. Routinely go through the drinking water register each year and verify or update details of network supplies. Promote compliance with the drinking-water requirements of the Health Act 1956 and achievement of the Drinking-Water Standards for New Zealand to drinking-water suppliers and water carriers, and undertake compliance and enforcement action as required. Conduct the annual review of drinking-water supplies serving more than 100 people and report to water suppliers as required by Scope 1. Assess water suppliers' water safety plans as required and provide a report to the water supplier within 20 working days. Ensure water safety plans include critical control points and promote the use of process control summaries by water supply staff. This will include a visit to the water supplier if the assessor is not familiar with the water supply, treatment plant and water supply staff. Assess and process applications as required	# water supplies surveyed in the annual review. # of water safety plans assessed. # of temporary drinking water supplies assessed and approved. # of water supplies where response was provided by Ngā Tai Ora to transgressions, contamination or interruption in accordance with drinking water legislation and standards.	% of water suppliers' water safety plans assessed and reported on within 20 working days. *Numerator:* # water safety plans assessed and reported on within 20 working days; *Denominator:* # water safety plans assessed within the reporting period. % of networked water supplies (by class of water supply) where timely response was provided by Ngā Tai Ora to transgressions, contamination or interruption in accordance with drinking water legislation and standards. *Numerator:* # networked water supplies (by class) where timely response provided. *Denominator:* # networked water supplies (by class) which reported transgressions, contamination or interruptions to the Ngā Tai Ora. Note: Ngā Tai Ora to assess risk accordingly and determine response within 24 hours on becoming aware of a P1 or P2 transgression, contamination or interruption.	#/% networked water supplies (broken down by class, that is, large, medium, minor, small and rural agricultural) compliant with sections 69V and 69Z of the Health Act 1956. *Numerator:* (broken down by class) # networked water supplies compliant. *Denominator:* (broken down by class) total # networked water supplies in area of coverage. Note: The above measure should be informed by the previous year's Annual Survey. #/% of water supplies serving 1000 people that are fluoridated. *Numerator:* # supplies fluoridate. *Denominator:* # supplies serving 1000 or more people.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
for the use of temporary drinking water supplies. Ensure water-suppliers have plans and Ngā Tai Ora responds in a timely manner to transgressions, water supply contamination or interruptions to the supply, including taking appropriate measures to protect and advise the community.			
4 Certify the implementation of water safety plans.	# water safety plan Implementation assessments undertaken.	*Narrative reporting:* *Nil.*	*Narrative reporting:* Nil.
5 Authorise organisations for the purposes of ensuring compliance with the Act, drinking water standards, and water safety plans.	# of authorisations/ calibration. # of compliance reports (water carriers).	*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
6 Report serious drinking water incidents to the Ministry of Health within 24 hours. Report suspected or confirmed waterborne disease outbreaks to the Ministry of Health within 2 hours.	# of incidents reported.	% of incidents reported to the Ministry of Health within 24 hours.	*Narrative reporting:* Nil.
7 Undertake enforcement activities in consultation with, and at the direction of, the Ministry of Health.	# of investigations related to enforcement (please specify in narrative).	% of enforcements that meet the standard criteria and guidelines. *Narrative* Why it isn't 100% (if it isn't).	*Narrative reporting:* Nil.
8 Refer issues and concerns with self-supplies to TAs as required.	# of referrals to TAs.	*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
9 Implement the requirements of the Drinking-Water Standards for New Zealand as required (eg P2 assignments, catchment risk assessments, secure ground water assessments). Ensure activities are integrated with the drinking water technical advice services for networked supplies serving up to 5000 people.	# of assessments related to requirements of the Drinking-Water Standards	*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
10 Provide technical advice and information on public health aspects of drinking water	A narrative highlighting the key ones that had significant public health issues will be	*Narrative reporting:*	*Narrative reporting:*

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
supplies, including the implications of the Health Act 1956 and the *Drinking Water Standards for New Zealand,* to water suppliers, councils, the public and organisations on issues of public health significance in respect to drinking water supplies.	reported.	Nil.	Nil.
11 Ensure that the public health effects of drinking water supplies are considered and managed by making timely submissions on: • regional and district plans and policies, including giving effect to the National Environmental Standard for drinking water catchments • territorial authority assessments of drinking water supplies • resource consent applications**.**	# of submissions made pertaining to drinking water.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.
12 Provide advice on the benefits of water fluoridation when the issue becomes a significant issue in the community by: • supporting health professionals who are promoting the extension or maintenance of fluoridated water supplies • ensuring appropriate education material is available to institutions, health professionals, territorial authorities, community groups and the public • ensuring that messages on fluoridation and oral health are consistent and current, and keep all health providers well informed • making timely submissions on water fluoridation when appropriate.	*Narrative reporting:* A summary of key activities undertaken by the Ngā Tai Ora regarding fluoridation advocacy will be reported.	% activities are aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.
13 Form collaborative arrangements with water suppliers, district councils and regional councils to share information about potential risks to drinking-water catchments, drinking-water supplies and other relevant issues.	Update on the activities undertaken by the Joint Working Group (JWG) and the 4 Waters Advisory.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
14 Carry out public health grading of drinking-water supplies at the request of drinking-water suppliers.	# of public health grading's undertaken.	% of public health grading's undertaken as per the Ministry of Health's guidelines.	
15 Provide drinking-water technical advice services for networked supplies serving 25 to 5000 people to protect the health and safety of people and communities by ensuring the adequate supply of safe and wholesome drinking-water, particularly communities with networked supplies (as defined in the Health Act 1956) serving between 25 and 5,000 people.	Report as per the contract specifications.	Report as per the contract specifications.	Report as per the contract specifications.
16 Undertake scoping and stocktake of drinking water self-supplies (focus on specified self-supplies).	*Narrative reporting:* A summary of progress made.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.
17 Provide ongoing education and awareness of cleaning and maintenance of tank water.	*Narrative reporting:* A summary of Ngā Tai Ora's work, especially Ngā Tai Ora's role and contribution to public health action in Northland.	% of health promotion messages that is, consistent with Ministry of Health and DHB messages.	*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.
18 Undertake a research project to map the public green spaces, parks, playgrounds and walkways and the availability of drinking water fountains.	*Narrative reporting:* A summary of progress made.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
19 Advocate among the Territorial Authorities (Councils) to increase the availability of drinking water fountains in the areas of high public activity.	*Narrative reporting:* A summary of progress made.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.

2.5.4 Environmental and border health

Recreational water

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Encourage local authorities to clearly identify, and publically notify, existing or potential recreational waters, which do not meet minimum microbiological water quality guidelines in the Ministry of Health/Ministry for the Environment Microbiological Water Quality Guidelines for Marine and Freshwater Recreational Areas. ***EOA***	*Narrative reporting:* A summary of e advocacy activities to improve public access and community safety while accessing recreational waters in Northland. *Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities to improve public access and community safety while accessing recreational waters in Northland.	% of activities aligned with Ministry of Health and DHB priorities. % of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of e actions/ contributions leading to improved health outcomes. *Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
2 Encourage the grading of bathing beaches, as outlined in the Microbiological Water Quality Guidelines for Marine and Fresh Water Recreational Areas.	# of recreational water incidents and inquiries attended to.	% of incidents and inquiries attended to as per the Health Protection manual.	*Narrative reporting:* Nil.
3 Respond to recreational water incidents and inquiries as required.	# of suspected or confirmed cases of toxic shellfish poisoning investigated.	% of investigations carried out as per the Ministry of Health regulations.	*Narrative reporting:* Nil.
4 Investigate cases of suspected or confirmed toxic shellfish poisoning.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities related to recreational water quality.	% of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
5 Provide input into regional and local activities associated with recreational water quality. Provide public and stakeholders with appropriate advice relating to recreational waters (eg public health fact sheets, media releases, updated website information).	# of advocacy activities undertaken.	% of information provided/advocated is consistent with the Ministry of Health guidelines.	% of public and school swimming pools in Northland that meet the NZS5826: 2010 Pool Water Quality requirements.
6 Encourage territorial authorities and pool managers (including school pools) to implement the requirements of NZS5826: 2010 Pool Water Quality to avoid or reduce public health risks.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities to improve public access and community safety while accessing recreational waters in Northland.	% of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.

Wastewater

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Conduct routine evaluation of the performance of controlling authority management of public health aspects of sewage collection and disposal with reference to statute, guidelines, standards, resource consent conditions and accepted public health practice.	# of evaluation activities undertaken.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
2 Investigate and assess, with an equity focus, the public health need for sewerage systems in areas not adequately serviced.	*Narrative reporting:* A summary of activities undertaken.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
3 Undertake sanitary and waste surveys as required.	# of sanitary surveys conducted by Ngā Tai Ora (if it is within the Ngā Tai Ora's responsibility).	*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
4 Provide a system for monitoring of significant public health risks in waste management.		*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
5 Liaise with councils to verify that sewage overflows that pose a significant public health risk are adequately responded to, engage with sewage collection and disposal providers to ensure overflows are appropriately managed and reduce overflows to high risk areas.	# of sewage spills attended to.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to reduced public health risks.
6 Promote, with an equity focus, improvements in public sewage collection and disposal systems where this is considered necessary.	# of advocacy activities undertaken.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to reduced public health risks.
7 Investigate, with an equity focus, clusters and cases of illnesses associated with non-occupational exposure to sewage or other waste. ***EOA***	# of investigations undertaken.		*Narrative reporting:* A summary of e actions/ contributions leading to reduced public health risks.

Hazardous substances

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Use the priority criteria in the Hazardous Substances Action Plan, and injury surveillance data, to develop hazardous substances programme plans. Report all notifications of hazardous substances injuries, including agrichemical spray-drift complaints, lead poisoning and poisoning arising from chemical contamination of the environment, to the science provider in the format required, including General Practitioner (GP) notifications.	# of public health HSNO enforcement officers. # of hazmat incidents or emergencies attended. # of cases of hazardous substances injuries that are notified by GPs, hospitals and others.	% of routine applications for Vertebrate Toxic Agent (VTA) permissions processed within 20 working days. *Numerator:* # routine applications processed within 20 working days. *Denominator:* # routine applications.	#/% audited VTA operations compliant with permit approval conditions. *Numerator:* # audited VTA operations compliant. *Denominator:* # audited VTA permissions.
2 Promote hazardous substances injury notifications by GPs. Participate in the Hazardous Substances Injury Surveillance System and other notifiable condition surveillance systems, including GP notifications via the Hazardous Substances Disease and Injury Reporting Tool (HSDIRT) system and according to Ministry of Health guidelines and direction.	# of VTA complaint investigations received and investigated. # of VTA complaints referred to another agency. # of response plans reviewed and revised, if necessary, following responses and exercises.	% of 1080 operations with permissions audited, either by desktop or field audit, for compliance with permission conditions (expected 100%). *Numerator:* # 1080 operations with permissions audited. *Denominator:* # 1080 operations with permissions.	*Narrative reporting:* Outcomes of promotion of the HSDIRT reporting process to GPs, hospitals and others.
3 Investigate notifications of lead poisoning, poisoning from chemical contamination of the environment, and hazardous substances injuries as required.	# of investigations/activities undertaken, by type (eg crayons, face paint, chemical spills).		
4 Audit compliance with, investigate breaches of, and where appropriate, enforce the relevant Acts and Regulations, including: • attending hazardous substances incidents as requested by Fire and Emergency NZ • surveillance of hazardous substances injuries and reporting via the HSDIRT system.	# of applications for Vertebrate Toxic Agent (VTA) permission received. # of applications for VTA permission issued. # of desk top audits of 1080 operations. # of field audits of 1080 operations. # of desktop or field audits of non 1080 operations.	% debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines, including the National Hazmat Response Plan, Major Response to Fires; guidelines for public health units (Revised 2014), Investigation and Surveillance of Agrichemical Spraydrift Incidents: guidelines for public health units. *Numerator:* # debriefs/audits that show that response was consistent with Plans, Ministry Guidelines, etc.	

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
	# of HazMat exercises attended.	*Denominator:* # of responses.	
5 Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk, for example, through assisting with recalls and public warnings as required.	# of area HazMat coordination committee meetings attended.		
6 Receive annual reports on methyl bromide fumigations. Maintain effective risk management strategies and response plans for HazMat incidents and emergencies, including deliberate chemical contamination and chemical fires, and including at designated points of entry. Responses are required to be consistent with the Ministry's advice and guidelines as noted in the service delivery expectations.			
7 Represent public health interests at meetings of the Area HazMat Coordination Committee. Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment by: • providing public health advice and information on hazardous substances and products to the public, health professionals and organisations • advising on the safe management of hazardous substances and products, including their removal and disposal from contaminated areas • advising on the safe management of asbestos in the non-occupational environment according to the Ministry of Health's guidelines and direction. • advising on the safe management of	# of meetings attended.		*Narrative reporting:* Outcomes of hazmat meetings and exercises.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
products containing lead, including lead-based paint and mercury (including its removal and disposal).			
8 Advise, encourage and/or assist territorial authorities and Regional Councils to: • identify potentially contaminated sites in the region and identify contaminants • implement health impact assessment systems to ensure contaminated land is remedied, where appropriate, and to minimise adverse effects on human health • determine appropriate land use controls for contaminated sites to minimise the risk to the public • ensure appropriate advice is provided to manage any public health risk from sites and during any remediation processes.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities.		*Narrative reporting:* Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.

Mosquito surveillance

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Undertake surveillance of mosquitoes at appropriate frequency (weekly over summer and warmer part of spring/autumn and fortnightly over winter and colder part of autumn/spring at international sea and airports or monthly audit of surveillance undertaken by the air or sea port company).	# of interceptions.	% of responses initiated within 30 minutes of notification. *Numerator:* # responses initiated within 30 minutes *Denominator:* # responses. *Narrative reporting:* On mosquito surveillance and whether it is occurring at appropriate frequency (will depend on weather and indicators, such as biomass).	#/% of exotic mosquitoes that have crossed the border and established in your region. *Numerator:* # incursions. *Denominator:* # interceptions.
2 Provide mosquito interception response situation reports to the Environmental and Border Health Team using the template in	# of incursions.		

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
the border health section of the Environmental Health Protection Manual.			
3 Respond promptly to interceptions of pests with human health significance (eg rats, ticks, poisonous spiders and cases of imported disease).	# of responses to other organisms.		

Border health

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Ensure designated points of entry achieve and maintain core capacities as required by the International Health Regulations 2005; audit core capacities annually as required by the Ministry of Health. Ensure all other ports of first arrival achieve and maintain as many core capacities as feasible for their situation.	# of authorised or accredited persons under the Biosecurity Act 1993. # of intersectoral meetings (#airports, # seaports). The 6-monthly 'Border Health Return for IHR Designated Points of Entry' will be completed and will report on: • progress from the previous year's verification • undertaking a random audit of selected capacities to verify that key core capacities have been maintained • training (individual and collective) • public health planning and contingency plans for emergency events • relationship building • vector control.	*Narrative reporting:* On requirements of a competent authority met by Ngā Tai Ora.	#/% of international points of entry that meet requirements of annual verification assessment under International Health Regulations 2005. *Numerator:* # international points of entry that meet requirements. *Denominator:* total # international points of entry in Ngā Tai Ora area of coverage.
2 Identify and monitor border health protection risks from biological (including pests and diseases), chemical and physical (including ionising radiation) hazards.	# of responses to border public health incidents.		#/% of international points of entry that have contingency plans to deal with ill travellers and other border health responses that are interoperable with public health response plans. Numerator: # international points of entry

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
			that have contingency plans. Denominator: # international points of entry.
3 Develop/ maintain contingency plans to deal with border health risks, including surveillance, ill traveller protocols, and border emergency response plans; work with border stakeholders to support the inclusion of public health response plans within sea and airport emergency response plans.			
4 Respond promptly to requests for pratique, inspections and certification (eg ship sanitation).	# of maritime pratiques issued. # of maritime pratiques issued on arrival. # of aircraft met on arrival. # of ship sanitation exemption, extension and control certificates issued.		
5 Attend border and other intersectoral meetings with relevant agencies and organisations on matters relating to border health protection.			
6 Provide sound technical and professional advice on public health issues that are related to border health protection objectives in relation to imported risk goods, disease vector surveillance and control, preparation of contingency plans for emergency response, preparation of submissions as appropriate on proposed pest management strategies.			
7 Provide public health training to air and sea port staff, as required, on border health protection risks and their management.	# of public health training (eg advice, update, event) to air and sea port staff.		
8 Contribute to or lead (when required) the preparation of equity-focused health impact assessments in relation to border health protection threats and eradication and			

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
control activities. ***EOA***			
9 Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.		% of current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course (expected 100%). *Numerator:* # current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course. *Denominator:* # current staff members involved in ship sanitation inspections.	

Emergency planning and response

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
1 Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies and according to Ministry of Health guidelines, plans and advice, and with an equity focus. ***EOA***			
2 Maintain and review Emergency Response Plan(s). There must be plans covering the following minimum areas: • Border Health Response • Communicable Disease – Outbreak/ Pandemic • Hazardous Substances (including radiation, hazmat responses, and Chemical and Biological Counter Terrorism Response) • Civil Defence/ National Disaster.	# of responses.	% of public health unit plans include reduction/readiness/response/recovery/resilience, and identify resources needed to support and carry out public health action (expected 100%). *Numerator*: # public health unit plans include the four 'Rs'. *Denominator:* # public health unit plans.	#/% of Ngā Tai Ora Emergency Planning and Response Plan interoperable with stakeholder plans (that is, TAs, DHBs, airport, seaport). *Numerator:* # interoperable Ngā Tai Ora /stakeholder plans. Denominator: total # stakeholder plans. *Narrative reporting:* Please report in narrative, if plans are not interoperable, on how you are working towards making plans interoperable. Definition of interoperable: The two Plans

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
			operate together seamlessly, are aligned and there is no discontinuity (eg if the airport EOC incident controller role is undertaken by the Police, then that is documented in the Ngā Tai Ora Plan).
3 Take appropriate equity-focused emergency actions, as the need arises. This includes liaison with and taking directions from other agencies involved, including providing services for, be directed by, and report to civil defence authorities. ***EOA***		% of plans and Standard Operating Procedures updated each year (required 100%). *Numerator:* # plans and Standard Operating Procedures updated. *Denominator:* plans and Standard Operating Procedures. Note: As a minimum the annual update should include a check to ensure that relevant contact phone numbers are still correct.	*Narrative reporting:* Outcomes of exercises. #/% of Health Protection Officers and Medical Officers of Health graduated from Coordinated Incident Management System (CIMS) 4 or CIMS (Health) training within the last four years. *Numerator:* # Health Protection Officers and Medical Officers of Health graduated from CIMS 4 or CIMS (Health) training within the last four years and currently employed. *Denominator:* # Health Protection Officers and Medical Officers of Health. *Narrative reporting:* If not 100%, please report on when they would be completing this training. Note: target should be 100% over a four-year period.
4 Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies, including national, regional and local meetings, exercise and training opportunities.	# of exercises.	% plans tested, including emergency communications (required 100%). *Numerator:* # plans tested. *Denominator:* # plans. Note: checking that all emergency phone numbers are still correct as a minimum.	
5 Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/ CIMS.		*Numerator:* # exercises and responses followed by a debrief. *Denominator:* # exercises and responses. Note: If the exercise is held by another agency and there is no debrief, the Ngā Tai	

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
		Ora should hold its own debrief.	
6 Ensure key health messages are available in educational and promotional materials through collaboration with other agencies/organisations involved in emergency planning and response.		% of debrief recommendations that are incorporated into plans and SOPs. Numerator: # debrief recommendations that are incorporated into plans and SOPs Denominator: # debrief recommendations.	

Other regulatory issues

Ngā Tai Ora, Public Health Northland Activity	**Measure**		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 For the following public health issues… • air quality • environmental noise • ionising radiation • non-ionising fields • gaseous, liquid and solid waste • other environmental health issues …with and equity focus, undertake the following: • provide information and advice to other agencies, organisations and the public on their adverse effects • take appropriate action to minimise risks and to protect the public health from environmental exposures to these issues • monitor territorial authorities' actions on these issues to ensure health impacts are minimised • respond to public enquiries and investigate and/or redirect public complaints and queries on these issues. Support local government implementation of national policy statements and national	# of ionising radiation source transports overseen. # of requests for advice or information responded to. # of complaints referred to the appropriate agency for action (where it is outside Ngā Tai Ora's responsibility). # of complaints investigated (where it is within Ngā Tai Ora's responsibility). *Narrative reporting:* Nature of any significant work not reported elsewhere eg Beauty/ appearance industry work such as nail bars.	% of activities and advice related to ionising radiation undertaken in consultation and with approval of the Ministry's Office of Radiation Safety (expected 100%). *Numerator:* # activities and advice related to ionising radiation undertaken in consultation with the Ministry's Office of Radiation Safety. *Denominator*: # activities and advice related to ionising radiation undertaken.	

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
environmental standards. ***EOA***			

Disinterment

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Ensure applications for approvals are complete, and include the health protection officer's covering report and recommendations before they are forwarded to the Ministry of Health for action, including: • disinterments • burials in special places • medical referee appointments • other burial and cremation approvals.			
2 Supervise disinterments as required.	# of disinterments supervised.	% of disinterments where both cultural and public health aspects were taken into consideration.	
3 Advise and assist applicants to export cadavers, as required, to ensure public health concerns are addressed. (Note that costs may be recovered for this activity.)			

Solaria

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Conduct six-monthly visits to commercial solaria to encourage compliance with best practice guidelines.	# of commercial solaria visited six-monthly.	% of visits to commercial solaria operators six monthly. *Numerator:* # visits to commercial solaria. *Denominator:* # known commercial solaria.	#/% of known commercial solaria operators who report they are aware of the under-18 age ban. *Numerator:* # known commercial solaria

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
			operators who report they are aware of the under-18 age ban. *Denominator:* # known commercial solaria operators in Ngā Tai Ora area of coverage.

Laser pointers

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Survey the availability of high-power laser pointers at retail outlets, provide advice on compliance and take compliance action as required by the Ministry of Health.			

2.5.5 Healthy food and drink

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Review the DHB 'Healthy Food and Drink' policy and align it with the national policy and to introduce 'water only' in the policy. Develop an implementation plan to implement the policy across the DHB.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities and progress made.		
2 Deliver the key activities promoting 'healthy food and drink' in Early Learning Services, schools and kura as per the 'Healthy Active Learning' contract from the Ministry of Health.	Report as per the measures identified by the Ministry of Health.		
3 Make submissions and advocate with relevant stakeholders for:	# of submissions made.		*Narrative reporting:* A summary of Ngā Tai Ora's

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
• 'Kai tax' to reduce costs of food • kai affordability • sustainable food production • community gardens (establishing, maintenance and sustainability) • access to quality kaimoana.			actions/contributions leading to improved public health outcomes.
4 Support the availability and continuation of Northland's 'Kai Ora' Fund and provide public health input.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities.	% of activities aligned with MoH and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/contributions leading to improved Māori health and reduced health inequities.
5 Advocate for a change in the supermarket design that promotes the visibility of healthy aisles, confectionary free lanes etc.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities.	% of activities aligned with MoH and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/contributions leading to improved public health outcomes.
6 Undertake scoping and effectiveness of 'Pataka kai' in collaboration with Māori Health Directorate.	*Narrative reporting:* A summary of the monitoring and analysis.		*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.
7 Identify the existence of food swamps, location, to eliminate them.	*Narrative reporting:* A summary of the monitoring and analysis.		*Narrative reporting:* A summary of the outcomes of Ngā Tai Ora's activities, including ways this work has impacted on Ngā Tai Ora's role and service delivery in Northland.

DHB activity	Milestone	Measure
8 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.	By Q4.	

2.5.6 Smokefree 2025

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort	**Quality of effort**	**Quantity and quality of effect**

	(How many did we do?)	(How well did we do?)	(Is anyone better-off?)
1 Conduct tobacco retailer visits for education and/or compliance purposes to ensure retailers are aware of their responsibilities under the Smoke-free Environments Act 1990.	# tobacco retailer visits for education and/or compliance purposes completed.		
2 Conduct CPOs to ascertain the level of sale of tobacco to minors. Note: One CPO equals one total organised operation that targets a number of tobacco retailer premises.	# CPOs conducted # tobacco retailers visited during CPOs.	% tobacco retailers visited during CPOs that are located in high priority communities1. *Numerator:* # tobacco retailers visited during CPOs that are located in high priority communities. *Denominator:* # tobacco retailers visited during CPOs.	#/% tobacco retailers that are compliant, at the time of CPO, with the provision of the Smoke-free Environments Act 1990 that prohibits tobacco sales to persons aged under 18 years) (BC, O). *Numerator:* # tobacco retailers that are compliant at the time of CPO with the provision of the Smoke-free Environments Act 1990 that prohibits tobacco sales to persons aged under 18 years. *Denominator:* # tobacco retailers visited during CPOs.

DHB activity	Milestone	Measure
1 Primary health implement fee for service funding model incentivising smoking brief advice (SBA) for Māori, wāhine Māori, hapū mama and Pasifika populations.	SBA team monitors the equity gap for people in the targeted populations who receive SBA, and practices are informed of identified gaps.	Increase % of Māori, wāhine Māori, hapū mama and Pasifika receiving SBA by GP clinics. ***EOA***
2 Stop Smoking Service (SSS) Lead Provider monitors and drives performance of SSS to achieve quit targets.	SSS Coordinator meets monthly with practitioners to monitor their progress. Lead provider meets monthly with funder to monitor regional progress.	Increase % of self-reported and CO-validated quits.
3a Increase Well Child Tamariki Ora collection of smoking status of infants at 6 week core check and subsequent checks to improve data quality.	WCTO QIF monitors collection of smoking status at core checks.	Increase the % of Māori babies living in smokefree households at six weeks. ***EOA***
3b Increase enrolments of Māori, wāhine Māori and hapū mama to Stop Smoking Service.	Smokefree Kaitaia provides Hapū Mama Incentive Programme, education and resources at Hine Koopu hapū wānanga.	# self-reported and CO-validated quits increases for: • Māori • Wāhine Māori • Hapū mama ***EOA***

[1] High priority communities include: low socio-economic (ie, deprivation index 7 – 10), Māori and Pacific populations, other ethnic minority groups, refugees and asylum seekers, tobacco retailers and licensed premises where there have been past complaints.

2.5.7 Breast screening

DHB activity	Milestone	Measure
Outcome: Northland has achieved positive health equity for Māori (current NDHB coverage is Māori women 74.5%, Pacific 60.3%, other 70.5%). We want to achieve close the equity gap for Pasifika:		
1 Implement a programme to reduce the equity gap for Pasifika women who are eligible for a breast screen.	Extract data from a PHO data match to identify new, not enrolled women, Q1. Contact all practices with eligible women to explore joint recruitment and retention initiatives with Pacific and Iwi provider support, including phone calls and/or home visits, Q2. Develop a communications strategy to create Pacific content with Pacific women, and advertise on the NDHB Facebook page and other appropriate places, Q2.	# new Pacific women enrolled. # engagements from posts. Equity gap closed for Pasifika women eligible to have a breast screen.

2.5.8 Cervical screening

DHB activity	Milestone	Measure
1 Review funding levels for cervical screening services in primary care to ensure sufficient resources for demand.	Work with primary care to understand funding challenges, Q1. Identify opportunities to meet any shortfall in funding requirements to meet Northland's population needs, Q1. Renew agreements with primary care by Q1.	Q2 and Q4,eliminate equity gaps in participation between Māori, Pacific and Asian women and non-Māori/ non-Pacific/ non-Asian women.
2 Implement the Northland Cervical Screening Programme Action Plan to achieve equity for Māori women receiving a screen.	Priority women are identified from data match for each practice Q1-4. Develop an improved referral pathway for Māori women with iwi and Māori health providers, Q2. Review performance through provider forum meetings to discuss best practice, collaborative approaches and offer support to practices who have not met targets, Q1-4.	Q2 and Q4, participation rate of at least 80% for Māori, Pacific and Asian women aged 25-69 years in the most recent 36 month period.

2.5.9 Reducing alcohol-related harm

Ngā Tai Ora, Public Health Northland	Measure

Activity	**Quantity of effort** (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Inquire into all on-, off-, club and, where appropriate, special licence applications, and provide Medical Officer of Health (MOH) reports to District Licensing Committee, either where there are matters in opposition or recommendations (on the basis of application of the relevant risk assessment tool in the Public Health Alcohol Regulatory Officer Toolkit, May 2013).	# applications and renewals. received for each licence type (on, off, club, special). # applications and renewals that were inquired into for each licence type (on, off, club, special).	% reports (for premises where matters in opposition were identified) provided to the District Licensing Committee (DLC) submitted within 15 days as per Sale and Supply of Alcohol Act 2012 for each licence type (on, off, club, special). *Numerator:* # reports (for premises where matters in opposition were identified) provided to the DLC submitted within 15 days for each licence type (on, off, club, special). *Denominator:* # reports where matters in opposition were identified for each licence type (on, off, club, special).	#/% applications where concerns were raised with the applicant prior to reporting to the DLC that resulted in either, amendments to the application and therefore no matters in opposition; or the applicant withdrew the application, for each licence type (on, off, club, special)2. (CC, O). *Numerator:* # applications where concerns were raised with the applicant prior to reporting to the DLC that resulted in either, amendments to the application and therefore no matters in opposition; or the applicant withdrew the application, for each licence type (on, off, club, special). *Denominator:* # applications where concerns were raised with the applicant prior to reporting to the DLC, for each

[2] This measure applies in circumstances where, prior to reporting to the DLC, the PHU has raised concerns with the applicant and the applicant has chosen to make '*significant*' amendment/s to the application to address the concerns raised, thereby resulting in either a no opposition report or the applicant withdrawing the application. If the amendment to the application was administrative only or an update of the Host Responsibility policy it should not be counted in this measure. '*Significant'* means: 'if the applicant hadn't made the change it is highly likely the application would have been opposed'.

Examples include:
- reduced hours or amended hours to fit within the LAP and/or national default hours.
- increased designation
- an amended single alcohol area which could include removal of end of aisles etc
- agreeing to a one-way door system (where an LAP does not exist).

Some of large events type examples could include:
- reduced serves
- reduced hours

Large events are sometimes a collection of smaller changes. Again, the test would be without these would have you opposed?
This differs from would you have opposed and won at the DLC.

It is something that would have made a difference.

'Significant' does not include, for example:
- an amended Host Responsibility Policy
- an increase in low or non-alcoholic options that is, little beyond meeting statutory requirements.
- a copy of a menu.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
			licence type (on, off, club, special). #/% reports for premises where the PHU submitted matters in opposition to the DLC, that were subsequently discussed with applicants, that resulted in applicant's either withdrawing or amending their application accordingly,3 for each licence type (on, off, club, special). (CC, O). *Numerator:* # reports for premises where the PHU submitted matters in opposition to the DLC, that were subsequently discussed with applicants, that resulted in applicant's either withdrawing or amending their application accordingly, for each licence type (on, off, club, special). *Denominator:* # reports for premises where the PHU submitted matters in opposition to the DLC for each licence type (on, off, club, special). #/% reports for premises where the PHU submitted matters in opposition to the DLC, which resulted in the DLC either attaching conditions to the licence or refusing to grant/renew the application/licence, for each licence type4 (on, off, club, special) (CC, O). *Numerator:* # reports for premises where the PHU submitted matters in opposition to the DLC, which resulted in the DLC either attaching conditions to the licence or refusing to grant/ renew the

[3] This measure applies in circumstances where the PHU has submitted a report to the DLC in opposition to the application which has resulted in subsequent discussion with the applicant who has then agreed to either withdraw their application or amend their application accordingly.

[4] This measure applies in circumstances where the PHU has submitted a report to the DLC in opposition to the application which has ultimately resulted in the DLC either attaching conditions to the licence or refusing to grant/renew the application/licence. Please report the outcome in your report that covers the six monthly period in which the DLC decision was made, because due to the inevitable time lag from submitting opposition to the release of a DLC decision the outcome may not always be able to be reported within the 6 month period in which the opposition was submitted.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
			application/licence, for each licence type (on, off, club, special). *Denominator:* # reports for premises where the PHU submitted matters in opposition to the DLC, for each licence type (on, off, club, special).
2 Collaborate in police-led Controlled Purchase Operations (CPOs), if any conducted, to reduce sale of alcohol to minors. (Note: One CPO equals one total organised operation that targets a number of premises.)	# CPO operations conducted[5]. # premises visited during the CPO operations.		#/% premises that are compliant, at the time of CPO, with the Sale and Supply of Alcohol Act 2012 (ie, no alcohol sale to the minor) (BC, O). *Numerator:* # premises that are compliant at the time of CPO. *Denominator:* # premises visited during CPO operations.

DHB activity	Milestone	Measure
3 Develop and implement policies that reduce alcohol related harm in an equity focussed settings based programme.	Implementation commenced across Early Childhood Education Services, Schools, Workplaces, Sports Clubs, Marae, retails and Local Government/HiAP. Q2 &4.	Policies shared across # settings
4 Facilitate initiatives to reduce alcohol-related harm through the development of an equity focused youth-orientated population health project .	Youth-orientated population health project developed Q2&4.	Youth-orientated population health initiatives implemented.
5 Development of a Northland Alcohol Harm Reduction Strategy with particular focus on equity for Māori.	Co-designed community alcohol harm reduction toolkits developed.Q2&4.	# organisations and communities supported in developing and implementing alcohol harm reduction strategies.

2.5.10 Sexual health

DHB activity	Milestone	Measure
6 Implementation of the new model of service delivery in partnership with key stakeholders.	Model of service delivery is implemented, increasing the provision of outreach nurse- led clinics, community youth workers and GPwSI consults for sexual and reproductive health across the region Q4.	# nurse outreach consults by clinic and treatment code for Māori rangitahi and adults. # GPwSI funded consultations.

[5] If no CPOs have been conducted, state the reason why.

DHB activity	Milestone	Measure
7 Development of a single Northland-wide sexual health promotion plan for rangatahi and youth living in rural areas.	Engage contracted providers to develop a plan for Northland Q2. Health promotion plan agreed. Key agreed messages and scheduled community awareness raising activities Q4.	Health promotion plans available across rural northland in spaces that are suitable for young people and rangatahi.

2.5.11 Communicable disease

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Deliver core activities and fulfil regulatory reporting, including updating of EpiSurv, as per legislative requirements and according to the Communicable Diseases Control Manual 2012. Ensure that cases of notifiable diseases including enterics are entered and updated in EpiSurv in a timely manner and all fields in the case report form are completed accurately.	# of notifiable diseases investigated. # of contacts traced.		# of secondary cases (occurrence) of any notified disease.
2 Provide timely, appropriate and consistent messages on enterics and communicable disease through use of social media and other effective channels of communication to the public, GPs, Community Pediatricians (eg Rheumatic Fever), Iwi/Whānau etc as relevant.	# of media releases made related to communicable disease.	The reach of social media messages to the public (# likes, interactions, comments etc).	Feedback from health professionals and the public regarding the messages.
3 Review a calendar years' worth of surveillance data (from EpiSurv) to determine if any trends or patterns are apparent, with a particular focus on inequities. ***EOA*** Disseminate key communicable disease surveillance data, issues and information to stakeholders (primary care, hospitals, lab etc).	# of regular communicable disease related bulletin/reports disseminated to stakeholders.	Peer-reviewed and high quality analysis undertaken with narratives.	
4 Review and update EID and Ngā Tai Ora	Updated and reviewed plans exist for the	Plan meets indicators of quality outbreak	MOH satisfied with quality of plan. In the

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
Emergency Plan and related planning. Undertake desktop outbreak response (eg measles across the region) or response to actual event, with a focus on equity. ***EOA***	Ngā Tai Ora. # of desktop exercises undertaken.	planning as per outbreak manual. % of staff involved in exercise.	event of an outbreak, plan provides useful guidance for Communicable Disease team. Staff debrief provides information for improvement.
5 Maintain ongoing capability and capacity to detect, investigate, assess and respond to cases and outbreaks of infectious diseases, pandemics, emergencies or other significant events with public health implications, including equity. ***EOA***	# of staff trained. # of desktop exercises undertaken.	% of staff attending relevant training sessions.	Review and debrief outcomes following the response to an outbreak.
6 Authorise dedicated needle and syringe exchange service providers in Northland as required. ***EOA*** Undertake observation visits (as capacity allows) to ensure needle and syringe exchange services adhere to and are operating within regulatory provisions and framework [that is Health(Needle and Syringe) Regulations 1998, the Misuse of Drugs Act 1975, other relevant legislation and subsequent amendments].	# of authorizations completed. # of observational visits undertaken.	Provider meets regulatory requirements.	# of IV drug users who contract acute Hepatitis C.

2.5.12 Cross-sectoral collaboration including Health in All Policies

DHB activity	Milestone	Measure
1 Provide strong leadership for public health policy by proactively identifying opportunities to influence agendas locally and nationally.	Expand the PHU relationships and influence with local councils and facilitate the sustainable implementation of equity-focused Health and Wellbeing in All Polices (HWiAP) across all of council. Q2&Q4. Co-develop a strategy to embed HWiAP at all levels across all sectors in Northland, including opportunities for evaluation and monitoring of HWiAP in Northland. HWiAP includes a focus on equity. Q2&4. Make timely and professional submissions on national and regional plans and policy statements, district long term and annual plans and,	Health and Wellbeing in All Policies approach adapted by councils. Submissions undertaken that promote public health policy. HWiAP strategy adopted.

DHB activity	Milestone	Measure
	where appropriate, resource consent applications to ensure that equity-focused public health effects are considered and managed. Q2&4. Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that equity-focused public health aspects of planning and resource management are considered Q2&4.	
2 Investigate and monitor housing in Northland, with a particular focus on equity, including but not limited to: • homelessness • overcrowding • social housing • housing affordability • quality of existing housing supply. ***EOA***	Q2, Q4 research projects developed.	Research undertaken.
3 Establish a sustainable social sector platform to bring together partners who have active roles in the social and cultural wellbeing of individuals, whānau and communities within Northland.	Identify and bring together social sector agencies.Q2&4.	Social sector collaboration platform initiated.
4 Staff will undertake the "Broadly Speaking" training in collaboration with local councils.	Broadly Speaking training delivered Q2&4	# PHU staff and council staff attending training.
5 Deliver on the Social Wellbeing Governance Group (SWGG)'s actions that pertain to Northland DHB. Monitor provision of Healthy Lifestyles programme.	SWGG will allocate lead agency actions against the 2020/21 work programme Q1. Report against NDHB actions Q2, Q3, Q4.	As listed in the SWGG outcomes and indicators frameworks.

Cross-sectoral activity is also mentioned in other parts of the Annual Plan:

2.1.1 Engagement and obligations as a Treaty partner action 2 (Social Accord).

2.3.1 Maternity and Midwifery workforce action 10 (AUT).

2.3.2 Maternity and early years actions 1 (Oranga Tamariki), 7 (Early Childhood Centres).

2.3.4 School-Based Health Services (secondary schools).

2.4.3 Addiction action 3.

2.5 Improving wellbeing through prevention numerous mentions throughout all …. sections, including territorial local authorities, government agencies, drinking water suppliers, Civil Defence, supermarkets, tobacco retailers, alcohol retailers.

2.6.8 Healthy ageing actions 1 and 6 (ACC).

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

These linkages above apply to all priorities under 2.6

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

2.6.1 Delivery of Whānau Ora

DHB activity	Milestone	Measure
1 Whānau-centred approaches and improved service delivery are addressed in [2.1.2 Accelerate the spread and delivery of Kaupapa Māori services, action 1].		
2 Supporting the Whānau Ora initiative and its commissioning agencies is addressed in [2.1.1 Engagement and obligations as a Treaty partner, actions 1 and 3].		

2.6.2 Care Capacity Demand Management

DHB activity	Milestone	Measure
1 Safe Staffing team to work with wards who have patient types outside their benchmarks to ensure these fall within Trendcare Gold Standards.	Trendcare audits carried out as per Trendcare Gold Standards Q1-4.	NDHB as a whole will increase from 79% compliance of milestones set by the Safe Staffing Health Unit to 100% compliance by Q4 2020/21. Wards have % actualisation (baseline 100%) Inter-Rater Reliability (IRR) (baseline over 90%). 100% implemented and BAU by June 2021.
2 Automate the Core Data Set (CDS) to enable data to be easy to access in a usable and effective manner.	CDS automated by Q3 2020/21. Each area to incorporate the data into their quality improvement initiatives Q3&4.	
3 Increase the Māori nursing workforce across Northland DHB hospitals in line with our Affirmative Action Plan.	Develop working agreements with NorthTec to increase the placements for registered nursing and enrolled nursing students for Māori, Q1-4.	Increase the baseline FTE calculations for all wards.

2.6.3 Disability Action Plan

DHB activity	Milestone	Measure
1 Develop a Northland Disability Action Plan.	NDHB's Equity in Community Committee endorse the co-development plan under Whaia Te Ao Marama by Q1. Co-design activities initiated Q2. Agree process for, and undertake an audit of 'accessibility' to meet needs of service users and staff, Q2&3. Draft Disability Action Plan completed for feedback from key stakeholders by Q3.	Feedback from # and % stakeholder engagement. Northland Disability Action Plan final draft ready for ELT Q4.

2.6.4 Disability

DHB activity	Milestone	Measure
Also refer 2.6.3 Disability Action Plan. System outcome: we have health equity for Māori and other groups.		
1 Promote mandatory Disability Responsive e-learning Training for frontline staff and clinicians, focusing on staff in Northland's regional hospitals.	Baselines to be confirmed from 2019/20 Q4 data.	Completion rates for new staff 80%. Completion rate for existing staff 80%.
2 Increase support for those who would benefit from having a Health Passport, focusing on those presenting to Northland's regional hospitals.	Contact visits completed across 3 regional hospitals.	% service contacts.

2.6.5 Planned Care

DHB activity	Milestone	Measure
The full realisation of a Planned Care Three Year Plan is a huge exercise because improving equity, access, quality, timeliness and experience for all patients involves changing (or even rebuilding) the current system. It is not an exercise that Northland DHB can do alone. Involvement is needed from across the Northland health sector, especially from primary care because what happens in health services in the community drives the needs that reach hospitals. Northland DHB is currently developing a Strategy, Northland Health 2040. There has been an extensive engagement process and we are about to embark in a process of developing high-level themes and directions. The Strategy takes a sector-wide approach in recognition that, as indicated in the Health and Disability System Review, fundamental changes need to happen to the current health system if it is going to achieve equity for all and meet current and future challenges. The Planned Care Three Year Plan is a natural fit with the Strategy and will evolve out of and alongside it.		

DHB activity	Milestone	Measure
1 Develop new Models of Care (MoC) in collaboration with Primary and Secondary Sectors that can improve equity, timeliness and access as well as patient experience.	Identify opportunities for patient referrals to be redirected to Primary Support Services prior to FSA (involve Multi-Disciplinary Team). Q1-4. Develop processes across secondary care that identifies priority populations (Māori, rural, low-socioeconomic) to facilitate First Specialist Appointments Q2. Develop relationships across planning and funding of primary and secondary care services to identify opportunities for shifting appropriate care and procedures into the community Q3. Develop a Planned Care action plan in response to the Northland Health 2040 strategy Q3&4.	Number of referrals that identifies the vulnerable patient increases by 5% per month commencing once RMS enables identification by referrer. Number of DNA for OPD and procedures will decrease by 2% annually by November 2021. Customer satisfaction measure will be developed and offered. Monthly review of 10% of those identified as vulnerable on referral will be reviewed ensuring quality, appropriate MDT involvement and consistent care.

2.6.6 Acute demand

Northland's plan for better managing patients in the community is captured within Appendix 2 System Level Measures Improvement Plan 2020/21, specifically in the sections for Ambulatory Sensitive Hospitalisations, Acute Bed Days and Amenable Mortality.

DHB activity	Milestone	Measure
1 *Acute data capturing.* Complete a qualitative survey of ED Māori patients presenting to Whangarei Hospital ED to identify ways of improving management of presentations and responding to the needs of Māori patients:	Establish baseline data to inform the co-design of a qualitative survey and engagement strategy with Māori whānau. Q1. Select an appropriate number and cohort of Māori patients to be invited to participate in the survey, Q1. Prioritise implementation strategies based on survey thematic themes and further engagement with Māori whānau, Q3.	Māori participation rates in survey and co-design process. Establish baseline # and % total annual ED presentations Māori and non-Māori; ED LOS Māori and non-Māori and admission rates.
Emergency department and hospital		
2 Promote the use of the Emergency Q app which enables people to make an informed choice about where to go for urgent care.	Establish baseline measures for presentations to ED Q1. Monitor issuance and redemption of vouchers to access Whangarei's primary urgent care facility Q2-4.	Reduction in the proportion of triage 4 and 5 patients visiting ED by 8 per day.
3 Import the new set of SNOMED codes from MoH into the ED clinical system.	Implement new system Q2, including brief training update on any new codes Q2.	

2.6.7 Rural health

Northland has a predominantly rural population; two-thirds live outside the Whangārei urban area, many in isolated locations along difficult country roads, and it takes over five hours to travel Northland north to south and up to two hours east to west. 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. Northland's rural and isolated populations form an inherent part of all our planning. Rurality is considered throughout the Annual Plan, both in actions with an explicit rural focus and those that take a Northland-wide view.
Rural health needs are explicitly addressed in:	
2.1 He Korowai Oranga all actions. 2.2.1 Improved out-year planning processes actions 1, 2, 3. 2.3.1 Maternity and Midwifery workforce actions 3, 6, 8, 9, 10. 2.3.2 Maternity and early years actions 1, 4, 6, 7, 8. 2.3.3 Immunisation action 1. 2.3.4 School-Based Health Services action 1. 2.3.5 Family violence and sexual violence action 1. 2.4.1 Mental health and addiction system transformation, actions 14, 16, 18. 2.4.2 Mental health and addictions improvement activities, action 2. 2.4.3 Addiction actions 2, 3. 2.4.4 Maternal mental health services actions 1,2. 2.5.1 Environmental sustainability actions 6, 7. 2.5.3 Drinking water all actions.	2.5.4 Environmental and border health almost all actions in all subsections. 2.5.5 Healthy food and drink, actions 2-7. 2.5.7 Breast screening actions 1, 2. 2.5.8 Cervical screening actions 2,3. 2.5.9 Reducing alcohol-related harm action 2. 2.5.10 Sexual health, whole section 2.5.11 Communicable disease, whole section 2.5.12 Cross-sectoral collaboration including Health in All Policies most actions. 2.6.1 Delivery of Whānau Ora all actions. 2.6.8 Healthy ageing action 1 2.6.14 Data and digital action 13. 2.7.1 Primary health care integration whole section. 2.7.2 Pharmacy whole section. 2.7.3 Long term conditions including diabetes whole section.

Other initiatives that aren't reflected in the MoH-driven priorities that form the basis of the Annual Plan are captured in the table

DHB activity	Milestone	Measure
1 Develop a new Northland Health Strategy (2.2.4 Working with sector partners to support sustainable system improvements, action 3).		
2 Develop a rural hospital pathway for rehabilitation.	Increased use of rural hospitals as part of care planning.	Utilization in bed day rates by locality and ethnicity.
3 Significant growth of Te Tumu Waiora Primary Mental Health initiative. 14 of the 20 newly funded FTE within the Primary Mental Health workforce will deliver services to rural General Practices in the Mid and Far North and rural	Q1 recruitment and training of new FTEs. Q1 14 FTE in place.	# of people having first contact. Total # people seen.

DHB activity	Milestone	Measure
Whangarei South.	Monthly performance monitoring.	Total # contacts. Wait time from referral to first seen.

2.6.8 Healthy ageing

DHB activity	Milestone	Measure
System outcome: we have improved quality of life.		
1 Increase the number of GPs and Pharmacists utilising Northland's osteoporosis and falls prevention pathways.	Targeted engagement with community pharmacists Q1-4. Fracture Liaison Service is actively managing communication with GPs for patients who would benefit from bone protection medication. Q1-4.	Maintain baseline of 60% of referrals to the high risk falls strength and balance programme being contributed by GPs/primary health care teams. Increase the percentage of patients presenting to ED with a fall or fragility fracture who are on bone protection medication from 34% to 50%.
2 Increase the prescribing of bone protection medication prior to hospital discharge for high risk falls patients.	Geriatrician-led engagement with SMOs, prescribing physicians and GPs Q1-4.	Increase the percentage of high risk falls patients prescribed bone protection medication prior to hospital discharge from 12% to 20%.
3 Develop a proposal for testing the capacity and flexibility of community based non-acute rehabilitation to support hospital capacity, patient flow and improve quality of care.	Proposal completed and implementation commenced Q1.	ED length of stay (Whangarei Hospital and Regional Hospitals). <28 day readmission rates by ethnicity, age, locality. Functional goals set at home achieved within 42 days, by ethnicity, age, locality.
4 Progress the work required to implement a nationally consistent Home and Community Support Services (HCSS) Service Specification.	National Service Specification endorsed and published Q1-4.	
5 Provide leadership to Northland's HCSS providers to develop their medication management systems and processes to meet the 2019 National Medication Guidelines for the home and community support sector.	Schedule of HCSS clinical audits completed Q2. NDHB and HCSS adopt an agreed process for supporting safe medication practices for people being supported at home Q3.	Clinical audits completed across # providers. # percentage of medication related findings out of total clinical audit to establish a baseline for future reduction.
6 Co-design HCSS contracting and service planning to ensure Kaupapa Māori Pathways for older Māori and their whānau are retained.	Co-design and engagement of contracting and service procurement of HCSS services Q2-3. Compulsory use of Tier Two Home and Community Support Services Specification by Q4.	# Māori whānau engaged in service design for the transitional nationwide description of HCSS Services.

DHB activity	Milestone	Measure
7 Implement an integrated Pressure Injury Prevention and Management (PIPM) Education and Training Programme.	Ensure that programme is in alignment with ACC requirements Q1. Identify community stakeholders, providers and informal carers to input into the training programme., Q2. 2020/21 project milestones met.	# provider, community and carer contacts. 15% reduction in community acquired grade 3 and 4 pressure injuries requiring hospitalisation (over the 2 year term of ACC Partnering Agreement).
8 Prioritise and progress priority actions identified from the 2019 national dementia care survey.	Work with Northern Regional planning and local NDHB context to agree top 3 regional priorities (via RSP), Q1. Develop and agree DHB Implementation Plans (via RSP), Q2.	Quarterly progress reports against NDHB implementation plan.
9 Progress the implementation of Geriatric Nurse Specialist screening for fragility using the modified BOPDHB, FRAILTY screening tool, and 4M gerontology assessment in ED.	A consistent "frail patient" assessment at the front door targeting those 80+years. Agreed patient flows and pathways to fast track patients through the hospital system (via RSP), Q4.	# ED presentations for those over 80 years. #/% 80 + years admitted from ED. <28 day readmission rates by ethnicity, age, locality.

2.6.9 Improving quality

DHB activity	Milestone	Measure
1 Undertake an ASH project to improve outcomes for children with asthma ***EOA***	See also the ASH section of Appendix 2 System Level Measures Improvement Plan 2020/21.	Reduce the number of tamariki Māori aged 0-4 years ASH rates by 3%: upper ENT respiratory infection from 1,726 to 1,674 by June 2021 asthma admission from 2,024 to 1,963 by June 2021. *(Copied from SLM plan)*
2 Participate in the new safety marker for consumer engagement.	Establish a governance group of staff and consumers to guide implementation of the marker. Submit local data via an online form using the SURE framework. Report against the framework annually by Q3.	
3 Progress Hand Hygiene promotion across NDHB's hospitals and clinical services.	Continue to monitor hand hygiene moments by submitting 100 moments per quarter of audited hand hygiene moments, Q-1-4. Require any area not meeting the 80% minimum requirement to provide an action plan to improve performance, Q1-4. Provide 2 training days t to improve and sustain good hand hygiene	Consistently maintain compliance of ≥80% for compliance with the five moments for hand hygiene target.

DHB activity	Milestone	Measure
	practice, Q3. Monitor performance and action plans where necessary.	
4 Implement the Zero Seclusion action plan.	See 2.4.2 Mental health and addictions improvement activities action 1.	
5 Progress the HQSC national project Connecting Care.	See 2.4.2 Mental health and addictions improvement activities action 2.	

2.6.10 System Level Measures

DHB activity	Milestone	Measure
Refer to Appendix 2 System Level Measures Improvement Plan 2020/21.		

2.6.11 New Zealand Cancer Action Plan 2019-2029

DHB activity	Milestone	Measure
Outcome: minimise breeches of the 62-day and 31-day FCT targets and ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway:		
1 Implement approaches to minimise breeches of the 62-day and 31-day FCT targets and ensure equity of access for Māori to timely diagnosis and treatment.	Use regional and local performance data and recommendations to streamline tumour stream pathways, particularly where inequity exists by monitoring quarterly reports to identify improvements required to meet FCT targets. Q1-4. Prospective identification, monitoring and intervention throughout the pathway by the CNS Māori/ PI Navigator to enable equity of access Q1-4. Establish networks with iwi providers and psychological support providers to improve equity of access by focusing on high risk Māori / Pacifica/ Q1-4. NDHB FCT reporting captures all new and current patients Q1-4. Stocktake of existing resources and gap analysis Q2. Analysis of the patients who did not meet the FCT targets (breech reports) Q1-4.	62 day and 31 day Faster Cancer Treatment targets: 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. 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.

DHB activity	Milestone	Measure
	Develop a patient information on cancer diagnosis and treatment for Māori using a health literacy approach Q3.	
2 Provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer:		
3 Establish post treatment pathways to enable patients to have improved quality of life and to live well beyond cancer.	Ensure that patients are referred to Cancer Society for ongoing care (survivorship), while maintaining Medical / Surgical oversight Q1-4. Establish self-care, mindfulness and allied health relationships to develop follow-up care plans for both secondary and primary health Q1-4. Establish a process to document on PMS (Concerto) "Patient Encounter" to ensure visibility to other services outside Cancer and Blood Services Q1.	Number of patients that receive referrals to complementary services across the system.

2.6.12 Bowel screening and colonoscopy wait times

DHB activity	Milestone	Measure
1 Implement improvement plans to reduce the wait times for non-urgent colonoscopy.	Source additional capacity where required in private settings Q1-4. Secure additional locum Endoscopists as required for Whangarei and Kaitaia Q1-4. Implement enhanced schedules to increase capacity on week days, evenings and weekends. Q1-4. Develop a priority process for non-urgent colonoscopy over surveillance Q1.	Waiting times targets as specified under SS15 in 5 Performance measures. 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 people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system. Consistently meet the bowel screening indicator 306 target that requires 95% of participants who
2 Commence and implement the Bowel Screening in Northland in line with the National Bowel Screening Programme.	Recruit staff required for the pre-implementation phase Q3. Set up governance and steering group structure for NBSP Q1. Develop and finalise budget for NBSP Q1. Confirm roles and staff requirements for the introduction of NBSP, with recruitment staged as appropriate Q4. Develop a Business Case for the recruitment of an additional full time permanent Gastroenterologist for 2020/21 in order to sustain this increased activity and maintain wait time targets prior to NBSP commencing Q1. Recruit two Gastroenterologists Q1-4.	

DHB activity	Milestone	Measure
	Meet requirements for readiness assessment prior to commencement of NBSP Q4.	returned a positive faecal immunochemical test (FIT) to have a first offered diagnostic date that is within 45 working days of their FIT result being recorded into the NBSP IT system. Achieve participation of at least 60% of people aged 60-74 years in the most recent 24-month period. Participation equity gaps are eliminated for priority groups.

2.6.13 Workforce

DHB activity	Milestone	Measure
1 Implement strategies to improve the wellbeing of the Northland DHB workforce.	Launch the Mayo Clinic Wellbeing Index so all staff at Northland DHB can measure their own wellbeing.Q2. Commission a review of current processes and procedures to effectively deal with bullying complaints, with recommendations for change implemented, Q3. Implement electronic nursing and midwifery portfolios through our online learning platform by Q3. COVID-19 has highlighted the requirement to explore a flexible working framework for staff that works within the current legislation (6aa Employment Relations Act 2000). To be agreed by the Executive Leadership Team, Q2.	Following the launch, percentage of all staff who will engage with the tool: 30% within three months 45% within six months 60% within nine months 70% within 12 months. Baseline of complaints regarding bullying established. Impact of changes monitored overtime with a view to reduced allegations.
2 Implement strategies to improve the leadership across the organisation.	Develop a pre-assessment evidence based methodology, based on the State Services Commission, to measure existing skills and gaps in leadership competencies. Offer competency assessment prior to the three existing leadership courses (instead of at the end as at present) for employees to self-assess with manager signoff. Develop flexible learning to address gaps. Develop enhanced training for leaders across the organisation. This to include competency assessment, and flexible training solutions to meet gaps Q2.	
3 Build a culturally competent Northland DHB workforce	Implement the Affirmative Action Plan, including reviewing the	Increase Māori workforce representation by a

DHB activity	Milestone	Measure
that can meet the needs of Māori patients and whānau.	Recruitment Policy and reviewing the HR Toolkit Q1-4. Develop cultural audits and introduce them in clinical settings to provide evidence of the current level of cultural competency. 3 audits conducted by Q2. Support the implementation of employee objectives to measure good cultural practices with associated guidelines and outcomes, Q2. Using the competencies identified in Equity of Health Care for Māori: A Framework, develop a competency assessment framework, Q3. Rationalise mandatory courses and review their impact on equity for Māori. Revise the content to align with policy requirements. Provide more flexible learning delivery options, bite-sized that better suit workplace, Q3. Complete ten interview audits to provide the organisation with information on the existing gaps in cultural competence and cultural safety, Q4.	minimum of 2% per year in each directorate (currently Māori participation across our whole workforce is 17%). Competencies will be visible through our reporting from the HRIS as an organisational and employee view. Staff achieving cultural competence through meeting objectives and achieving certificates through training.
4 Roll out the Workplace Violence Prevention (WVP) Framework and Implementation Plan.	Undertake a review and sign off on Work Placed Violence policy and procedures Q2. 2020 De-escalation Calendar of Training available for all staff with workshops fully booked by Q3. Undertake the Lone Worker Safety Review and trial new training for three months Q2. Provide specific intensive WVP support to high risk areas within the DHB Q1-4.	June 2020-Mar 2021, at least 3x 6 month WVP Pilots underway and completed.
5 Ensure that NDHB's payroll systems are compliant to legislation, including the Holidays Act.	Payroll to update the current HRIS to comply with the Holidays Act Rectification project phase Rectification phase of the Holidays Act Compliance project by Q2. Identify issues of system non-compliance and rectify with compliance measured via auditors, Q1-4.	Compliance to requirements confirmed by auditors.

2.6.14 Data and digital

DHB activity	Milestone	Measure
Regional collaborative community care (RCCC) programme The vision of the Regional Collaborative Community Care (RCCC) programme is to enable an integrated, collaborative, organised, patient-centred network of primary, community and		

DHB activity	Milestone	Measure
hospital based care settings for the Northern Region, providing care as close as possible to the home and emphasising prevention (including self-care and health promotion), consumer participation and consumer autonomy, supported by an integrated technology solution.		
1 Replace Northland's JADE Mental Health and Community Care Information System to provide a regional solution.	Commencement of negotiations with preferred vendor, Q1. Mobilisation and contract execution (subject to successful negotiations), Q2. Commencement of Design Phase, Q3. Approval to proceed to Build, Q4.	Successful negotiation. Complete design for RCCC. MoH approval to proceed to build as per conditions on SSBC.
Health record transformation programme		
2 Implement electronic referral capabilities between Northland DHB services, NDHB to community providers, and NDHB to other DHBs for specialist care	Technical deployment completed by Q4. Internal DHB services will be trained and using the system by Q2.	75% of Northland DHB internal-hospital referrals are electronic by Q2. 80% of referrals to Northland DHB from community providers are electronic by Q2.
3 Implement a new information system to enable data capture and reporting for Northland's Renal service with a view to it becoming a regional platform .	System live Q1 2020/21. Existing Renal patients transferred to Renal Reality Q2. New patients registered and monitored through Renal Reality Q2.	All renal patients loaded onto new system.
4 Commence mobilisation design, build, test and deployment of eOrders solution across Acute, Inpatient and Outpatient services.	Business case approved by NDHB Board and MoH, and project initiated by Q1. Detailed designs completed Q2. System built and tested by Q4.	Progression of business case and development of system.
5 Enhance WebPAS patient information system data flows to and from specialty systems.	Project completed Q4 2020/21.	Improved patient demographic and event data from ED. Integration with regional visit view. Enhanced appointment and referral information.
6 Prepare business cases for electronic vitals management and electronic medicines management.	Vitals management business case submitted for Board approval Q2. eMedicines management business case submitted for Board approval Q4.	Business case approved.
7 Implement a digital system for hand-over notes and hospital at night management across the hospital wards.	System improvements live by Q2. Changes to business processes adopted across Kaitaia and regional hospitals Q2. Adoption of safer hospital at night practices within Whangarei Hospital by Q4.	Improved risk identification.

DHB activity	Milestone	Measure
Northern Region IS strategic plan (ISSP)		
8 Move onto the regional clinical portal (the newest version of Concerto)to mitigate a serious business risk arising from using unsupported hardware and software.	System live by end of Q2. All NDHB users will be using Regional Clinical Portal by Q3.	Transition to regional clinical portal.
9 Implement the Workspace programme to reduce risk by modernising the desktop operating system, office tools and remote access.	Completion of design workshops, Q1. Deployment and migration started in or by Q1. Deployment complete by Q3.	90% of Windows 7 devices have been upgraded to Windows 10 by Q3 2020/21. All users have been migrated to Exchange Online and OneDrive by Q3 2020/21. All entitled users are able to user the new Remote Access solution. All existing SharePoint sites will be migrated to SharePoint online where possible, and plans will be in place for those that need alternative solutions.
10 Improve the way data is shared across the region to support collaboration across care settings.	API Operating Model agreed Q1. Health Provider Directory development underway Q2. API Integration commenced against agreed regional design. eASK strategy agreed Q3.	
Other Northland DHB initiatives		
11 Drive uptake of telehealth more broadly and rapidly across NDHB, leveraging on past experience and an effective telehealth tool (Zoom). *(See also action 3 in 2.7.1 Primary health care integration.)*	Telehealth Action Group (TAG) established to engage strategically across the organisation, identifying and prioritising concepts for action, Q2. Deploy service-wide to oral health, extend our acute telehealth network to Rawene Hospital, provide telehealth capability to Ngawha Corrections Facility, Q3. Concepts agreed and prioritised with quick wins being actioned as BAU, and business cases developed for projects. Q3 2020/21. Projects completed, Q4.	

2.6.15 Implementing the New Zealand Health Research Strategy

DHB activity	Milestone	Measure

DHB activity	Milestone	Measure
1 Establish a research partnership with the Health Research Council to improve health equity for Māori.	Project scoped for Māori uptake of bowel screening and submitted Q1.	Partnership established. Funding secured for project.
2 Partner with Auckland Metro DHBs to further research possibilities such as discussing Northland DHB's involvement in regional research and analytics with our regional partners who have a number of projects underway, including trauma research. The updated Cloud-based data warehouse will support this.	Update cloud bases data warehouse Q4. Complete negotiations with research partners. Contract signed Q4.	Data warehouse functional in Cloud. Signed contract with research partners.
3 Develop a framework to maximise research and innovation activities across Northland DHB.	Framework developed and deployed.	Count of research projects underway and completed.

2.6.16 Delivery of Regional Service Plan priorities and relevant national service plans

DHB activity	Milestone	Measure
1 Dementia care. Addressed in action 8 in 2.6.8 Healthy ageing.		
2 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.		

2.6.17 Pacific Health Action Plan

DHB activity	Milestone	Measure
1 Northland DHB is committed to implementing *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025*.	Strategy developed in partnership with Northland Pacific community. Support development of a Pacific-led mobile nursing service. Locally developed strategies to support growth of pacific workforce.	

DHB activity	Milestone	Measure
	Support continued growth and contribution of Northland pacific community issues to regional developments.	

2.7 Better population health outcomes supported by primary care

These linkages above apply to all priorities under 2.7

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

2.7.1 Primary care integration

DHB activity	Milestone	Measure
Northland DHB remains committed to ensuring patients have the easiest possible access to the correct level of care. Through the ongoing promotion and adoption of new technologies, initiatives and models of care, Northland DHB will continue to reduce and mitigate barriers to care, including travel, cost and other factors which particularly impact our rural, dispersed and deprived populations. Increasing the types of clinics, consults, and other patient interactions that can occur outside a hospital setting is a key overall action theme in this mission. The recent COVID-19 response necessitated rapid implementation of some of these initiatives and our intention is to continue sustaining these innovations in the post-COVID 'business as usual' setting. These initiatives will primarily target high needs populations with low historical levels of participation at the promotion, prevention and minor intervention end of the care continuum.		
1 Invest into primary and community provisions that enable patients to receive *timely* access to care, improve their care experience, and receive enhanced interventions that reduce the potential to use hospital services.	Implement a community hub with centralised triage and scheduling processes out to community nursing and allied health *services*. • compile and agree processes necessary to enable the 'Community Hub' to function.Q1 • first referrals into hub received Q3 • expand the hub's capacity and capability throughout Q3 & Q4. Expand the range of interventions available within primary care to reduce the demand on hospital services and patients Q1-4. Identifying & implement care pathways within primary care for planned care interventions, including development and implementation of planned care initiatives. Q1-4.	% 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. % increase in POAC uptake by high needs populations. % reduction in avoidable admissions of high needs populations. % increase in planned care intervention activity in primary care settings.
2 Invest *and develop models of primary care that promote sustainability for the workforce and patients.*	All practices with enrolled populations greater than 5000 have been actively encouraged and assisted to implement Neighbourhood Healthcare Homes, Q3. Invest in change programmes to enable the sustainable use of electronic solutions that enable greater primary-secondary	% increase in phone triage. % increase in patient interaction through electronic means. % decrease in secondary care outpatients non-

DHB activity	Milestone	Measure
	integration including • electronic shared care planning • electronic prescribing • electronic referrals • virtual multidisciplinary-team sessions • patient portals • Telehealth Q1 2020/21. Follow up with any remaining practices yet to adopt e-prescribing to ensure 100% availability to all patients, Q1. Ensure a second cohort of clinicians are trained on the Calderdale framework across hospital and primary settings, Q4. All known unenrolled Northland residents have been contacted and encouraged to enrol, Q4.	attendance.

2.7.2 Pharmacy

DHB activity	Milestone	Measure
Northland DHB continues to recognise the important role that community pharmacists play in improving patient health outcomes. The recent management of COVID19 demonstrated the vital role that pharmacy play in providing easy access to health advice for Northlanders, with significant demands placed on pharmacies across the district. For several years NDHB and representatives have operated a service development group which identifies, develops and funds specific services that target areas of health need in addition to those pharmacy services in the national community pharmacy agreements. As well as the specific activities below, Northland DHB continues its intention to implement the activities outlined in the Strategic vision for Community Pharmacies and Pharmacists in Northland 2019-2026 document.		
1 Invest in additional pharmacy-delivered services across Northland improving access to provision for high needs patients and that can demonstrate reduced demand on general practice by expanding the skillset and contribution of the pharmacy workforce.	Two new local services piloted across Northland by Q3. Scope and develop a comprehensive medicine use review programme through community pharmacy with business case developed for sustainable funding, Q4.	Baseline measures identified that are relevant to measuring success for the implemented projects. 2 new local services developed. Business case for Comprehensive Medicines Use Review completed.
2 Embed the utilisation of national electronic initiatives, particularly those accelerated in the COVID-19 response such as e-prescribing.	Every Northland pharmacy able to accept e-scripts, Q2.	% increase in e-scripts through community pharmacies.
3 Promote pharmacists as a vaccination option for MMR / influenza and expand the availability of other immunisations in community pharmacy.	Pertussis vaccination available to pregnant women in community pharmacy, Q2. Implement lessons learned from accelerated 2020 influenza season	% increase in contribution to vaccination rates attributable to community pharmacy.

DHB activity	Milestone	Measure
	to ensure influenza vaccine coverage of eligible patients remains comparable or better than 2021 influenza season, Q4.	

2.7.3 Long term conditions, including diabetes

DHB activity	Milestone	Measure
The management of diabetes and associated conditions has been identified as a *significant* area for improvement both nationally and locally. In response Northland DHB has established a Diabetes Governance Group charged with developing an overarching strategy for diabetes care in Northland. This strategy must focus on the '*upstream*' components of care which requires strong working links with our primary care *partners*.		
1 Operationalise the Northland Diabetes Strategy across Northland.	Diabetes strategy signed off by ELT, Q1. Action plan developed to implement the strategy across Northland. Q2. Service plans updated to ensure successful delivery of the plan, Q2.	As highlighted in the strategy.
2 Implement a population health outcomes performance framework and action plan in partnership with primary care with an overarching focus on the management of patients with diabetes, CVD and other long term conditions with a focus on achieving equity for Māori.	Performance framework agreed, Q3.	% increase of diabetes annual review rates, with a key measurable focus on Māori. % increase in CVD risk assessments in Māori. % increase in earlier intervention of potential serious podiatry complications. % reduction in adverse outcomes (including incidences of high risk feet referrals, and lower extremity amputations).
3 Implement a new Green Prescription model which integrates with other active lifestyle funding streams that drive equitable delivery and the ongoing promotion of better self-management of health outcomes.	New model negotiated with provider, Q1. new model fully implemented, Q3.	Increase in number of self-reported positive life style changes achieved. Increase in Māori accessing a green prescription service.

2.7.4 Air Ambulance Centralised Tasking

DHB activity	Milestone	Measure
1 Northland DHB is committed to actively participating with the National Ambulance Sector Office (NASO) in the design and planning phases to centralise the tasking and	As *required* by NASO.	

DHB activity	Milestone	Measure
coordination of *aeromedical* assets in New Zealand.		

2.8 Financial performance summary

Statement of Comprehensive Income $000s	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
DHB Provider Revenue	393,972	416,771	458,414	476,750	495,820	515,653
DHB Funder Revenue	291,267	307,716	320,282	333,093	346,417	360,274
DHB Governance & Administration	(0)	(0)	(0)	(0)	(0)	(0)
Inter District Flow Revenue	10,881	11,572	11,358	11,812	12,284	12,776
Total Revenue	696,120	736,058	790,054	821,656	854,522	888,703
DHB Provider Operating Expenditure	399,711	414,981	434,196	451,564	469,627	488,412
DHB Non Provider Funded Services	213,177	232,316	231,026	240,267	249,878	259,873
DHB Governance & Administration	347	511	383	399	415	431
Inter District Flow Expense	84,181	84,376	100,591	104,615	108,799	113,151
Total Operating Expenditure	697,416	732,183	766,197	796,845	828,718	861,867
Earnings before Interest, Depreciation, Abnormals & Capital Charge	(1,296)	3,875	23,857	24,811	25,804	26,836
Less						
Interest on Term Debt	126	506	446	464	482	502
Depreciation	14,030	15,163	15,887	16,522	17,183	17,870
Net Operating Surplus (Deficit)	(15,452)	(11,794)	7,524	7,825	8,138	8,464
Capital Charge	9,282	8,078	7,500	7,800	8,112	8,436
Surplus (Deficit)	**(24,734)**	**(19,872)**	**24**	**25**	**26**	**27**
Revaluation of Fixed Assets	0	0	0	0	0	0
Comprehensive Income	**(24,734)**	**(19,872)**	**24**	**25**	**26**	**27**

Statement of Movements in Equity $000s	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
Equity at the beginning of the period	159,560	141,432	129,399	160,223	195,049	241,076
Surplus/Deficit for the period	(24,734)	(19,872)	24	25	27	27
Total Recognised Revenues and Expenses	134,826	121,560	129,423	160,249	195,075	241,103
Other Movements						
Revaluation of Fixed Assets	0	0	0	0	0	0
Other	7	(11)	0	0	(0)	0
Equity introduced (Repaid)	6,600	7,850	30,800	34,800	46,001	11,000
Equity at end of Period	**141,432**	**129,399**	**160,223**	**195,049**	**241,076**	**252,103**

Statement of Financial Position

$000s

	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
Equity						
Crown Equity	65,005	71,605	79,455	110,255	145,055	191,055
Retained Earnings	(33,130)	(53,002)	(52,979)	(52,953)	(52,926)	(52,900)
Subsidiaries & unrestricted trusts	215	203	203	203	203	203
Revaluation Reserve	102,743	102,744	102,744	102,744	102,744	102,744
Equity Injections	6,600	7,850	30,800	34,800	46,000	11,000
Total Equity	141,432	129,399	160,223	195,049	241,076	252,102
Represented by:						
Assets						
Current Assets	31,308	28,846	28,476	29,259	30,558	34,089
Non-Current Assets	235,112	238,908	269,421	302,810	346,402	353,532
Total Assets	266,421	267,754	297,897	332,070	376,960	387,621
Liabilities						
Current Liabilities	105,779	119,668	119,434	119,101	118,310	118,310
Non-Current Liabilities	19,210	18,687	18,239	17,919	17,574	17,208
Total Liabilities	124,988	138,355	137,673	137,021	135,884	135,518
Net Assets	**141,432**	**129,399**	**160,223**	**195,049**	**241,076**	**252,103**

Statement of Cash Flows

$000s

	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
Cash Flows from Operating Activities						
Operating Income	690,727	739,858	789,045	820,607	853,431	887,568
Operating Expenditure	684,323	729,117	774,770	804,645	836,831	870,304
Net Cash from Operating Activities	6,404	10,741	14,275	15,962	16,600	17,265
Cash Flows from Investing Activities						
Interest receipts 3rd Party	601	419	255	265	276	287
Sale of Fixed Assets	18	0	0	0	0	0
Purchase of Fixed Assets	(22,721)	(18,615)	(43,400)	(46,411)	(57,675)	(22,000)
(Increase)/Decrease in Investments and Restricted & Trust Funds As	(1,629)	(970)	(3,000)	(3,500)	(3,100)	(3,000)
Net Cash from Investing Activities	(23,731)	(19,166)	(46,145)	(49,646)	(60,499)	(24,713)
Cash Flows from Financing Activities						
Equity injections (repayments)	6,600	7,850	30,800	34,800	46,000	11,000
Borrowings introduced (repaid)	7,320	(280)	(590)	(462)	(345)	(366)
Interest Paid	(126)	(506)	(446)	(464)	(482)	(502)
Other Non-Current Liability Movement	7	0	0	0	0	0
Net Cash from Financing Activities	13,801	7,064	29,764	33,874	45,173	10,132
Net Increase/(Decrease) in Cash held	(3,527)	(1,362)	(2,106)	191	1,274	2,684
Add opening cash balance	6,439	2,912	1,550	(556)	(365)	909
Closing Cash Balance	2,912	1,550	(556)	(365)	909	3,593

Consolidated Statement of Financial Performance ($000s)	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
MOH Devolved Funding	655,766	693,935	749,219	779,188	810,355	842,770
MOH Non-Devolved Contracts (provider arm side contracts)	15,556	16,002	15,411	16,027	16,669	17,335
Other Government (not MoH or other DHBs)	6,778	8,138	8,658	9,005	9,365	9,739
Patient / Consumer sourced	834	566	451	469	488	507
Other Income	5,052	4,622	3,728	3,877	4,032	4,193
IDFs - All Other (excluding Mental Health)	10,881	11,572	11,358	11,812	12,284	12,776
InterProvider Revenue (Other DHBs)	1,253	1,224	1,229	1,278	1,329	1,382
Total Consolidated Revenue	696,120	736,058	790,054	821,656	854,522	888,703
Personnel Costs	275,524	285,197	299,179	311,146	323,592	336,536
Outsourced Services	40,343	44,092	42,964	44,682	46,469	48,328
Clinical Supplies	52,956	54,248	58,760	65,937	68,574	71,317
Infrastructure & Non-Clinical Supplies	31,235	31,954	33,677	30,197	31,405	32,662
Finance Costs	9,408	8,584	7,946	8,264	8,594	8,938
Depreciation	14,030	15,163	15,887	16,522	17,183	17,870
Personal Health	195,807	200,457	214,458	223,036	231,958	241,236
Mental Health	16,841	19,565	21,902	22,778	23,689	24,637
Disability Support Services	77,546	82,804	86,627	90,092	93,695	97,443
Public Health	1,722	6,996	694	721	750	780
Maori Health	5,442	6,869	7,937	8,254	8,584	8,928
Total Operating Expenditure	720,854	755,931	790,029	821,631	854,496	888,676
Surplus (Deficit)	**(24,734)**	**(19,873)**	**24**	**25**	**26**	**27**

Provider Statement of Financial Performance ($000s)	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	15,556	16,002	15,411	16,027	16,669	17,335
Other Government (not MoH or other DHBs)	6,778	8,138	8,159	8,485	8,824	9,177
Non-Government & Crown Agency Sourced	5,886	5,188	4,179	4,346	4,520	4,700
InterProvider Revenue (Other DHBs)	1,253	1,224	1,229	1,278	1,329	1,382
Internal Revenue (DHB Fund to DHB Provider)	364,498	386,219	429,437	446,614	464,479	483,058
Total Provider Revenue	393,972	416,771	458,414	476,750	495,820	515,653
Personnel Costs	275,524	285,197	299,179	311,146	323,592	336,536
Outsourced Services	40,343	44,092	42,964	44,682	46,469	48,328
Clinical Supplies	52,956	54,248	58,760	65,937	68,574	71,317
Infrastructure & Non-Clinical Supplies	30,889	31,444	33,294	29,799	30,991	32,230
Finance Costs	9,408	8,584	7,946	8,264	8,594	8,938
Depreciation	14,030	15,163	15,887	16,522	17,183	17,870
Total Operating Expenditure	423,149	438,728	458,029	476,350	495,404	515,220
Surplus (Deficit)	**(29,177)**	**(21,957)**	**385**	**400**	**416**	**433**

Governance Statement of Financial Performance ($000s)	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
Government & Crown Agency Sourced	0	(0)	(0)	(0)	(0)	(0)
Total Governance Revenue	0	(0)	(0)	(0)	(0)	(0)
Infrastructure & Non-Clinical Supplies	347	511	383	398	414	431
Total Operating Expenditure	347	511	383	398	414	431
Surplus (Deficit)	**(347)**	**(511)**	**(383)**	**(398)**	**(414)**	**(431)**

Funder Statement of Financial Performance ($000s)	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2022-2023 Budget	2023-2024 Budget
MOH Devolved Funding	655,766	693,935	749,219	779,188	810,355	842,770
Inter District Flows	10,881	11,572	11,358	11,812	12,284	12,776
Total Funder Arm Revenue	666,646	705,506	761,076	791,519	823,180	856,107
Personal Health	507,188	533,855	586,545	610,007	634,407	659,783
Mental Health	62,125	64,553	68,000	70,720	73,549	76,491
Disability Support Services	84,407	89,665	95,210	99,018	102,979	107,098
Public Health	2,362	7,637	1,547	1,608	1,673	1,740
Maori Health	5,774	7,201	9,752	10,142	10,548	10,970
Total Operating Expenditure	661,856	702,911	761,054	791,496	823,156	856,082
Surplus (Deficit)	**4,790**	**2,596**	**23**	**24**	**25**	**25**

Key Financial Analysis and Banking Covenants

	2018-19 Audited Actual	2019-20 Forecast	2020-21 Budget	2021-22 Budget	2021-22 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	124,988	138,355	137,673	137,021	135,884
Debt	9,095	8,813	8,223	7,761	7,416
Owners Funds	141,432	129,399	160,223	195,049	241,076
Total Assets	266,421	267,754	297,897	332,070	376,960
Owners Funds to Total Assets	53%	48%	54%	59%	64%
Interest Expense	126	506	446	464	482
Depreciation Expense	14,030	15,163	15,887	16,522	17,183
Surplus/(Deficit)	(24,734)	(19,872)	24	25	26
Interest Cover	(84)	(8)	37	37	37
Debt/Debt + Equity Ratio	6%	6%	5%	4%	3%
Banking Covenants					
Debt/Debt + Equity Ratio	6%	6%	5%	4%	3%
Interest Cover	(84)	(8)	37	37	37
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

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.

At the moment there are no major service changes planned for 2020/21. Northland DHB is not intending to make any service changes as a result of our response to Covid-19. While we have reviewed our Covid-19 processes to refine and improve them, we are not planning on initiating any formal reviews.

Change	Description of change	Benefits of change	Change for local, regional or national reasons
Repatriation of interventional radiology	Cardiac Cath Lab and Angiography, PCI as well as other forms of interventional radiology that may be repatriated during 2019/20.	Service provided closer to home for Northland patients. More cost effective service delivery.	Regional
New approach to primary health	Northland DHB intends to explore new ways of working with Mahitahi Hauora to ensure we maximise opportunities for working under the articles of Te Tiriti, better health and social care coordination, and locality driven healthcare, working as a single team, co-commissioning in partnership, improving GP and Māori Provider engagement, and co-governance.	Greater locality (patient, whānau, community and provider) driven planning and investment. Improved efficiency and effectiveness. Front-foot recommendations in the Health and Disability System Review.	Local
Repatriation of Cardiac MRI	The majority of Cardiac MRI procedures will be undertaken in Northland rather than at the Centre for Advanced MRI (CAMRI) at the University of Auckland with reporting via ADHB. This affects approximately 33 patients per annum.	Reduces travel and subsequent costs for patients and whanau and improves equity. Facilitates NDHB to attract and maintain a skilled workforce.	Regional

Extra FTEs

Our priorities for the next twelve months remain focused on equity and accessibility and include increased investment into Māori Health, Planned Care, Diabetes and our vulnerable services. We are also focused on shifting more services from hospital to community services, enabling our non SMO workforce, kaiāwhina, working at a top of scope strategy, and building on the positive service developments and virtual care models that emerged during the COVID-19 response.

Key investment priorities for FY20/21 are:

Māori Health Equity (6 FTE)

Shifting more services to the community (7 FTE)

Diabetes (2 FTE)

Child and Maternal Health (2 FTE)

Renal (3 FTE)

Increased theatre capacity (14 FTE)

Vulnerable services – including Ophthalmology, ED, Labs, and rural services (13 FTE)

Safer after hours care (7 FTE)

New graduate nurses and CCDM (16 FTE)

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 4.1.4.

4.1.2 Funding and financial management

Key high-level figures/assumptions

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.

4.1.4 Shared service arrangements and ownership interests

The Northland DHB group consists of the parent, Northland DHB, and Kaipara Joint Venture Trust (54% 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
    - https://www.fmhs.auckland.ac.nz/en/soph/about/our-departments/epidemiology-and-biostatistics/research/hgd/research-themes/imd/maps.html 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.

4.2 Building capability

4.2.1 Capital and infrastructure development

Northland DHB is currently revising the Whangarei Hospital master plan and Northland DHB Clinical Services Plan to support the submission mid 2020 of 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 on the Whangarei Hospital campus include an Endoscopy Theatre, additional Theatre Capacity and a Cardiac Cath Lab.

A further business case for capacity and critical compliance works valued at $166m was submitted and $48.2m was approved by the Minister. This enables a third floor to be added to the maternity unit with the second floor of maternity to be fitted out for a new paediatric and SCBU ward and fitout of a new laboratory on the third level. The approved funding provides:

- sufficient bed capacity through to 2023
- compliant accredited new laboratory

We believe a change request or new business case is now needed (SSBC3) to address the unresolved issues from SSBC2:

- condition and health and safety risks
- infrastructure upgrades
- Emergency Department capacity
- Radiology capacity

In the north of the region, the project team is working on stage two of the Bay of Islands hospital redevelopment The design has been tendered via the open competitive market resulting in a preferred contractor being identified and a total project cost of $12.0m. This project cost is $4.9m over the approved funding, subsequently Northland DHB has requested guidance from the Ministry of Health on the budget shortfall and have developed two options with estimated costs for consideration. These have been presented in a change request to both Ministry and CIC for consideration at the July CIC meeting. If the preferred option to address the existing building non-compliance and health and safety issues is not funded a third stage will be required to address this, acknowledging the residual risk until funding is made available.

Work is also commencing on a business case for Kaitaia Hospital to address weathertightness and condition issues following $10m prioritisation in the recent infrastructure fund.

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

Annual capital bid approval processes see bids assessed 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 currently rewriting its Asset Management Strategy, Policy and Plan to support its asset management practices.

4.2.2 Information technology and communications systems

Northland District Health Board continues to develop its capability in Information Technology and Communications. The focus for 2020/21 continues to be increasing digital capabilities through the Health Record Transformation Programme. This programme enables data and interoperability to support the direction of collaboration and integration across care settings supporting equity of access to services and evidence based care.

To further increase IT capability in Northland work is underway with developing an investment portfolio of initiatives across core capabilities such as digital maturity while balancing service demand, change management and resourcing impacts on the organisation. This investment planning informs the Regional 10 year IS Financial Plan. To ensure success in digital investments and transformation, Northland is focussing on strengthening local governance and clinical leadership, supported by the regional governance framework under the Information Systems Strategic Plan (ISSP).

Underpinning Northland's aspirations the Northern Region 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, and deliver the vision of an integrated regional health system. A key element and enabler 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 and network capability, making it easier for providers and consumers to access the data and systems available (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 goal is to standardise on a small number of core systems, fill in some core functional gaps and progressively phase out the many hundreds of small applications that make up our complex IS landscape and constrain the way the system works. Implementation of an Application Portfolio Management (APM) tool is complete. Data is being used to prioritise and inform application lifecycle management and investment. A number of major applications projects are also under way which will provide platforms that will enable application consolidation and rationalisation to occur eg the Regional Community Collaborative Care (RCCC) and Hospital Administration Replacement Project (HARP) which will enable access of key health information to consumers. While initial implementations of these systems are local to a DHB, the intent is for these to be regional.

Become experts at 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. The Data Sharing and Interoperability project is implementing several key aspects of the strategy including a Health Provider Directory. As the products selected in the HARP and RCCC projects are selected, aspects of the strategy that are not delivered will need to be addressed eg regional document management and vendor-neutral data storage.

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

The ISSP has investment pathways that support key objectives of the Ministry, including the development of a strategy for consumer access to their health information, with the subsequent initiation of projects to progressively implement it.

The strategy is informed by the Health System Design Council's principles for Northern Region IS systems, which include:

- consumers/ whānau/ patients are the centre of our health system and they "share us/ their providers"
- consumers can see all their health information in one place/ application (a single portal) and interact with their providers with seamless processes to allow collaborative, coordinated care
- providers "share patients"; we work together to support and care for our patients by sharing information, communicating with each other and our patients with processes that are transparent, shared and person centred
- we provide self-management resources, patient decision support pathways and wherever possible enable patients/ whānau to look after their own wellbeing.

Cyber security plans and required investment in 2020/21 are being finalised but continue to build on the solid foundations that have been established. Subject to funding, the aim will be to build on foundational security incident event management (SIEM) tools and resources – to further embed a cyber security controls framework which complies with HISF / NZISM and Ministry of Health digital service requirements.

IS roadmaps to enable the Long-Term Health Plan 'Deep dives' – HR / workforce, primary and community care, cancer – will be approved and initiatives identified.

4.2.3 Workforce

Organisational culture and workforce development

Staff wellbeing continues to be an organisation priority. Building on the success of the launch of the Employee Wellbeing Programme additional plans will be implemented including a wellbeing self-assessment tool, a review of security protocols, and additional leadership development opportunities and support.

We will attract, recruit and develop a talented workforce. An updated employee value proposition and branding will be implemented, while we will accelerate the recruitment of Māori through a new Workforce Equity role. We will continue to grow the capacity and capability of our Māori workforce, with a further 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 will be enhanced through the Calderdale Framework with a further cohort of staff, 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.

We have implemented a suite of leadership and management training courses and will be initiating additional support and tools for new leaders.

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 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 2.6.13 Workforce. 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.

A NIF operational leadership group has also been formed of key managers who have the ability to implement suggested cross sectoral approaches to outcomes within their various agencies.

5 Performance measures

Performance measure		Expectation		
Improving child wellbeing				
CW01	Children caries free at 5 years of age	Year 1	47.4%	
		Year 2	47.4%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	0.92	
		Year 2	0.92	
CW03	Improving the number of children enrolled and accessing the Community Oral Health Service	Children (0-4) enrolled: ≥95% of preschool children (aged 0-4) will be enrolled in the COHS	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall: ≤10% of preschool and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	> or = 85%	
		Year 2	> or = 85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,		
CW09	Better help for smokers to quit (maternity)	90 percent 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.		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.		
Improving mental wellbeing				
MH01	Improving the health status of	Age 0-19		

Performance measure		Expectation	
	people with severe mental illness through improved access	Māori Other Total	5.11% 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 day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.	
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	(expectation to be confirmed)	
Improving wellbeing through prevention			
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	Ensuring delivery of Regional Service Plans	Provide reports as specified	
SS03	Ensuring delivery of Service Coverage	Provide reports as specified	
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified	
SS05	Ambulatory sensitive hospitalisations (ASH adult)	4,500	
SS07	Planned Care Measures	Planned Care Measure 1: Planned Care	

Performance measure		Expectation		
		Interventions		
		Planned Care Measure 2: Elective Service Patient Flow Indicators	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care 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).
		Planned Care 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. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 6: Acute Readmissions	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	11.7%
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
SS08	Planned care three year plan	Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing 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, unknown and dot (.) in	>76% and < or equal to 85%

Performance measure		Expectation		
			line 1	
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC 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, milestones and measures to support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care.	
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.	
			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 2a, registry completion: >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 and…	
			Indicator 2b: ≥ 99% within 3 months.	
			Indicator 3, ACS LVEF assessment: ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie 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:	

Performance measure		Expectation	
			Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), Beta-blocker if LVEF<40% (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 PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services: provide confirmation report according to the template provided	Indicator 1 ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: Inpatient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient 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 people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system	
SS17	Delivery of Whānau Ora	Appropriate progress identified in all areas of the measure deliverable.	
SS18	Financial outyear planning & savings plan	Provide reports as specified	
SS19	Workforce outyear planning	Provide reports as specified	
Better population health outcomes supported by primary health care			
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period	

Performance measure		Expectation
	PHO and NHI registers	and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent or above
PH04	Primary health care: Better help for smokers to quit (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

Appendix 1 Statement of Performance Expectations

The Statement of Performance Expectations (SPE) tells our 'performance story', activities we carry out to improve the health of Northlanders and contribute to a better society. 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 sections 1, 2.8 and 4 of the Annual Plan comprises our Statement of Intent.

The SPE concentrates on cornerstone measures that are representative of the wide range of services for which Northland DHB is responsible. By and large the SPE's measures are selected from among the Ministry of Health-driven measures in the Annual Plan. Wherever possible, measures are by Māori and non-Māori so we can monitor inequities.

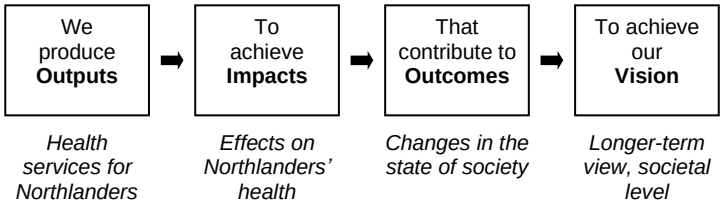
Output classes

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 (see table on the next page).



Impacts contribute to Outcomes, and together they contribute to High-level Outcomes. 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
- services that are of high quality, 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.

Summary of Statement of Performance Expectations 2020/21

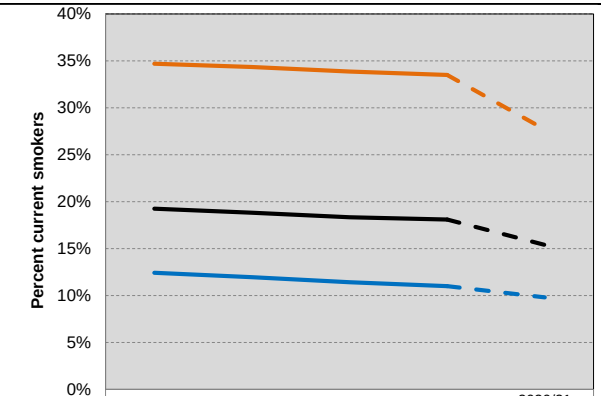
All measures by Māori and non-Māori where data is available.

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 com-munity 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	**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	% adults who are current smokers % 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 % 8-month-olds who have their primary course of immunisation on time Average number of decayed, missing or filled teeth in Y8 students % 4-year-olds identified as obese in B4 School Checks will be offered a referral to a health professional	Ambulatory sensitive hospitalisation ages 0-4, rate/100,000, unstandardised	% 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 % 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	% people with enduring mental illness aged 20-64 who are seen over a year	% patients admitted, discharged or transferred from and ED within 6 hours	% older patients assessed for risk of falling; those at risk who have individualised care plans % of opportunities for hand hygiene taken Surgical site infections per 100 hip and knee operations where antibiotic is given 0-60 mins before 'knife to skin' Patient deterioration: % patients with early warning scores calculated correctly; % patients who triggered an escalation of care and received the appropriate response	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 assess-ments 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	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	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



	2016/17	2017/18	2018/19	2019/20	2020/21 Q4 target
Total	19.3%	18.8%	18.3%	18.1%	15.4%
Maori	34.7%	34.4%	33.9%	33.5%	27.7%
Non-Maori	12.4%	11.9%	11.4%	11.0%	9.8%

Measure type: Coverage

Rationale

Smoking, along with obesity, is the most significant driver of long term conditions.

Currently 33.3% of Māori and 11.0% of non-Māori smoke. (This data, which comes from Northland's PHE, does not match with NZ Health Survey data, but it is preferred for this purpose because it is produced quarterly and permits regular monitoring.)

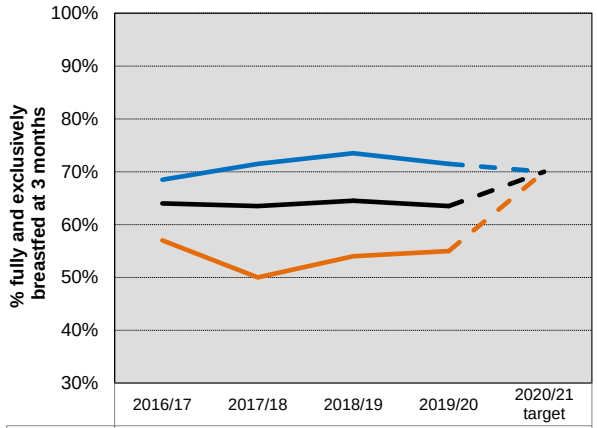
New Zealand has committed to a goal of reducing smoking rates to 5% by 2025. The dotted lines in the graph reflect the percentage drops required in 2020/21 to make straight-line progress towards reaching the 2025 target. Non-Māori smoking rates are reducing at about the desired rate, but Māori smoking rates need to decline faster.

Outputs

Primary care records show 117,583 Northlanders who have ever smoked, of whom 24,468 are current smokers (2019/20 Q3).

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

Measure: Full and exclusive breastfeeding at 3 months



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	64%	64%	65%	64%	70%
Maori	57%	50%	54%	55%	70%
Non-Maori	69%	72%	74%	72%	70%

Measure type: Coverage

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 should have a significant effect on improving the health of Māori over time.

Outputs

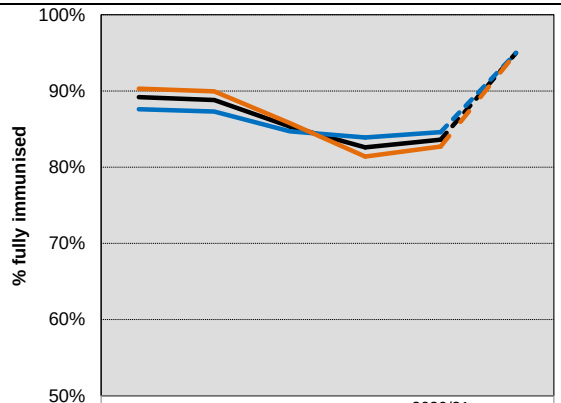
Total NDHB hospital births: 2,094 for the twelve months ending March 2020.

828 lactation consultant patient contacts for the twelve months ending March 2020.

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



	2016/17	2017/18	2018/19	2019/20	2020/21 target	
Total	89.2%	88.8%	85.3%	82.6%	83.6%	95.0%
Non-Maori	87.6%	87.3%	84.7%	83.9%	84.6%	95.0%
Maori	90.3%	89.9%	85.8%	81.4%	82.7%	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 (currently 11% for 8-month-olds) for parents declining to have their child immunised or opting off the National Immunisation Register. Various approaches are used to encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage.

Outputs

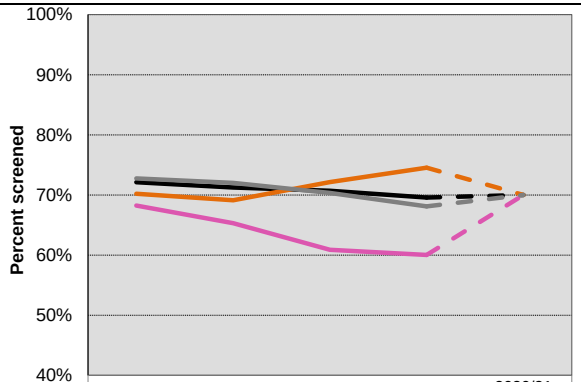
1.964 children were fully immunised before 8 months of age during the twelve months ending March 2020.

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

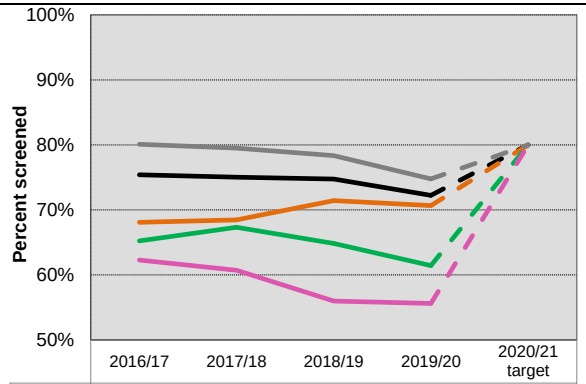
Measure type: Coverage



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	72.1%	71.3%	70.7%	69.6%	70.0%
Maori	70.2%	69.1%	72.2%	74.5%	70.0%
Pacific	68.3%	65.3%	60.9%	60.0%	70.0%
Other	72.8%	72.0%	70.4%	68.1%	70.0%

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

Measure type: Coverage



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	75.4%	75.0%	74.8%	72.2%	80.0%
Maori	68.1%	68.5%	71.4%	70.7%	80.0%
Pacific	65.2%	67.3%	64.8%	61.4%	80.0%
Asian	62.3%	60.7%	56.0%	55.6%	80.0%
Other	80.1%	79.5%	78.4%	74.8%	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. Screening programmes have existed in New Zealand for many years for breast cancer and cervical cancer, and bowel cancer screening is currently being established.

Outputs

17,460 eligible women were screened in year to March 2020, including 4,579 Māori and 12,881 non-Māori.

Outputs

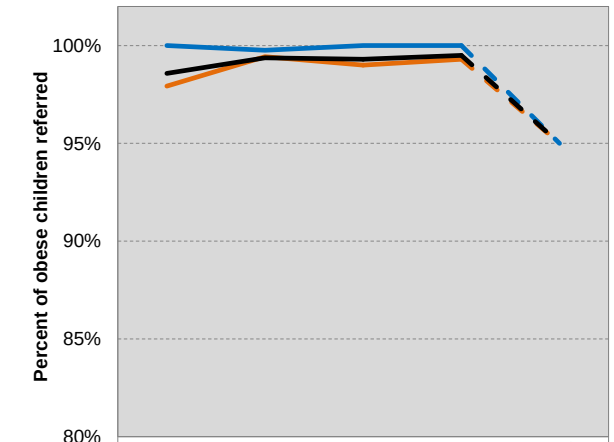
33186 eligible women screened in the three years up to March 2020, of whom 9,658 were Māori and 23,528 were non-Māori.

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	2019/20	2020/21 target
Maori	97.9%	99.4%	99.0%	99.3%	95%
Non-Maori	100.0%	99.8%	100.0%	100.0%	95%
Total	98.6%	99.4%	99.3%	99.5%	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.

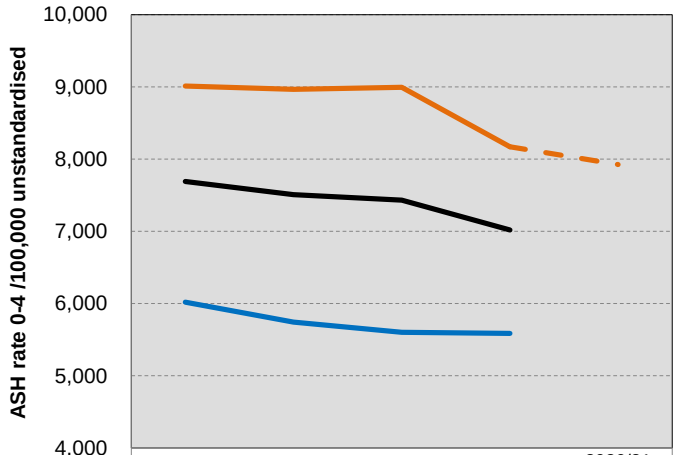
Outputs

1,915 4-year-olds checked June 2019-May 2020.

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

Measure

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



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	7,690	7,507	7,431	7,019	
Maori	9,011	8,966	8,995	8,170	7,925
Other	6,019	5,742	5,602	5,587	

Measure type
Quality

Rationale

Ambulatory sensitive hospitalisations (ASH) are potentially avoidable if patients are seen by primary care services, and their conditions diagnosed, then cured or well managed.

ASH admissions form a substantial proportion of hospitalisations and affect Māori inequitably.

Lowering ASH rates not only improves the health of patients, it also frees up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar. This requires 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.

Outputs

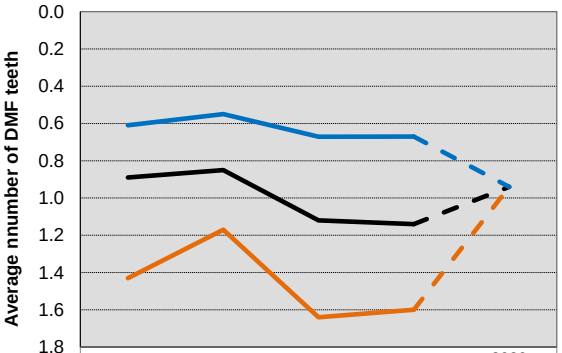
822 ASH discharges ages 0-4 year to March 2020, of whom 527 were Māori.

The Māori-only target is based on the one in the SLM plan (appendix 1 in the Annual Plan 2020/21): "reduce ASH rate for tamariki Māori by 3%".

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:



	2016	2017	2018	2019	2020 target
Total	0.89	0.85	1.12	1.14	0.94
Maori	1.43	1.17	1.64	1.60	0.94
Non-Maori	0.61	0.55	0.67	0.67	0.94

Rationale

Poor oral health doesn't just affect the state of teeth and gums. It also creates pain and discomfort, limits what children can eat, affects self-image and confidence, and has links to other types of ill health.

For many years Northland had among the worst oral health statistics for children, though some 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.

Outputs

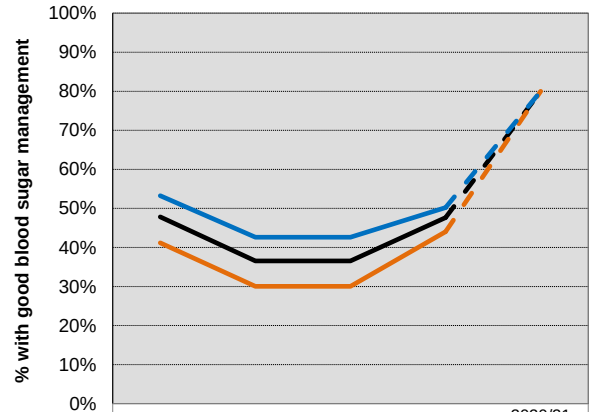
1,085 Year 8 students were treated by NDHB's services in CY 2019.

Values on the y axis have been reversed because the lower this measure the better.

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

Measure: % of diabetics aged 15-74 who receive annual free checks who have good blood sugar management

Measure type:
Coverage



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	47.8%	36.5%	36.5%	47.6%	80.0%
Maori	41.2%	30.0%	30.0%	44.0%	80.0%
Non-Maori	53.3%	42.6%	42.6%	50.2%	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.

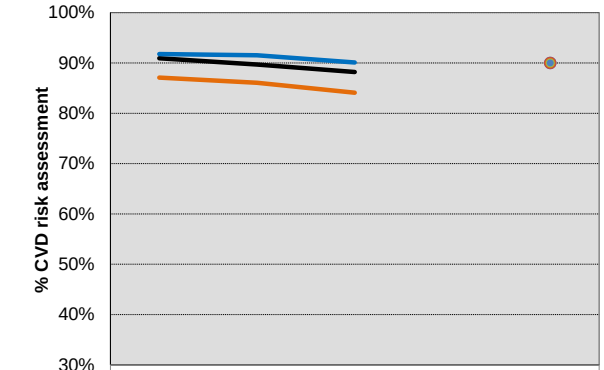
Accurately monitoring progress on this measure is difficult because over the last few years the Ministry has changed the criteria for the denominator several times.

Outputs

As at Dec 2019 6,010 people were on the Northland diabetes register, of whom 487 were Māori and 5,523 non-Māori.

Measure:
Eligible people receiving cardio-vascular (CVD) risk assessment in the last 5 years

Measure type:
Coverage



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	90.9%	89.7%	88.2%		90.0%
Maori	87.1%	86.0%	84.1%		90.0%
Non-Maori	91.8%	91.5%	90.1%		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.

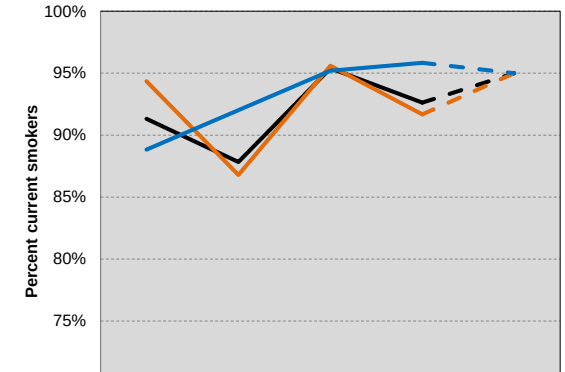
Regular screening identifies those at risk of developing cardiovascular disease, and its onset can be prevented or delayed by lifestyle and clinical interventions. Regular screening also helps earlier identify those who already have the condition.

Outputs

102,707CVD risk assessments performed in primary care over the five years to March 2020, of whom 31,917 were the high-risk groups of Māori, Pacific or Indian, and 70,790 were other ethnicities.

There is no data yet for 2019/2. Data is reported in Q2 and Q4 but Q2 reporting was put on hold due of covid-19 and Q4's data had not appeared at time of writing.

Measure: % of pregnant women offered brief advice and support to quit smoking



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	91.3%	87.8%	95.4%	92.6%	95.0%
Maori	94.4%	86.8%	95.6%	91.7%	95.0%
Non-Maori	88.8%	92.0%	95.2%	95.8%	95.0%

Rationale

Smoking and obesity are the two most significant drivers of long term conditions. Smoking puts babies at higher risk of conditions such as glue ear, asthma, leukemia and Sudden Unexplained Death in Infancy (SUDI).

Currently 33.3% of Māori and 11.0% of non-Māori smoke.

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

Outputs

Primary care records show 117,583 Northlanders who have ever smoked, of whom 24,468 are current smokers (2019/20 Q3).

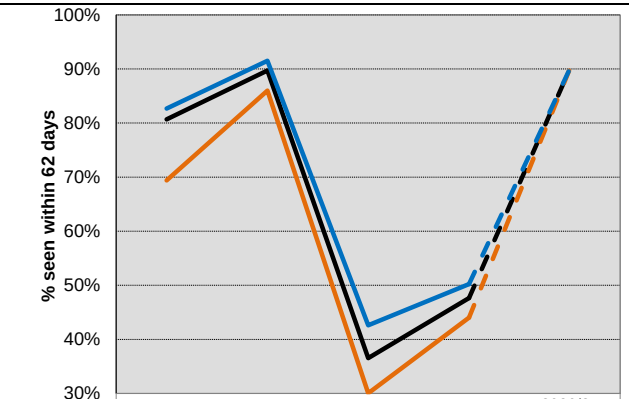
2019/20 data is Q1 and Q2 only. No data was reported in Q3 due to covid-19 and Q4's data had not appeared at time of writing.

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

Measure type: Coverage



	2016/17	2017/18	2018/19	2019/20	2020/21 target
Total	80.7%	89.7%	36.5%	47.6%	90.0%
Maori	69.4%	86.0%	30.0%	44.0%	90.0%
Non-Maori	82.7%	91.5%	42.6%	50.2%	90.0%

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.

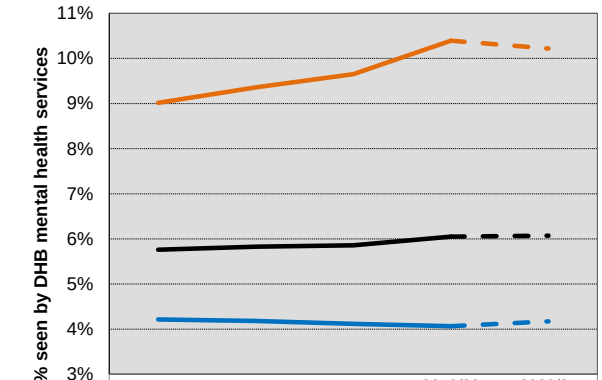
Outputs

269 patients referred urgently with high suspicion of cancer for the twelve months ending March 2020 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



	2016/17	2017/18	2018/19	2019/20 to Q2	2020/21 target
Total	5.76%	5.83%	5.86%	6.05%	6.07%
Maori	9.02%	9.36%	9.65%	10.39%	10.22%
Non-Maori	4.22%	4.18%	4.12%	4.06%	4.17%

Rationale

Severe mental disorders permanently affect 3% of the total population, though prevalence is higher among Māori.

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

The guiding document in NZ is *Rising to the Challenge*, the national mental health and addictions strategy 2012-2017.

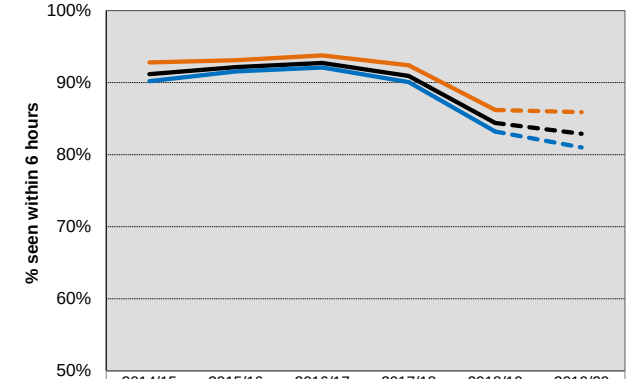
Outputs

5,817 clients aged 20-64 as at June 2020.

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	2019/20
Total	91.2%	92.2%	92.7%	90.9%	84.4%	82.9%
Maori	92.8%	93.1%	93.8%	92.4%	86.2%	85.9%
Non-Maori	90.2%	91.6%	92.1%	90.1%	83.2%	81.0%

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 2019/20 Q3 45,251.

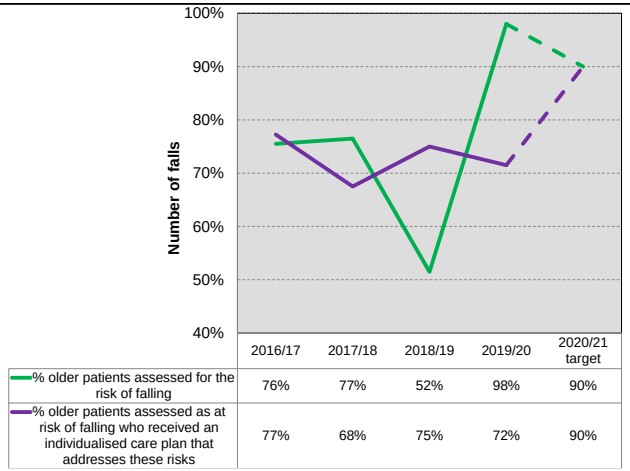
Impact: Fewer adverse clinical events.

Measures type: Quality

% older patients assessed for the risk of falling

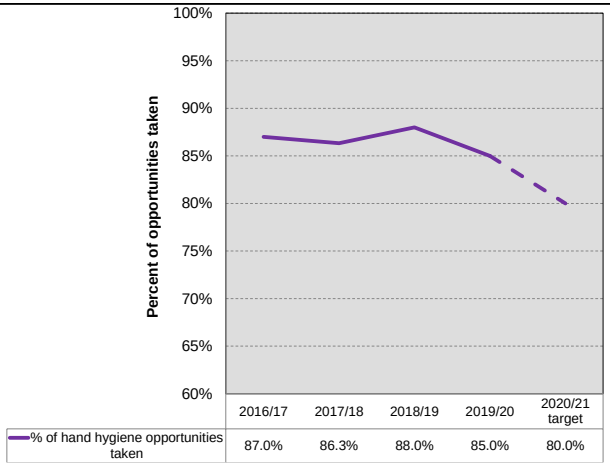
% older patients assessed as at risk of falling who received an individualised care plan that addresses these risks

Replaces former measure of fractures of neck of femur whose numbers were very small.



	2016/17	2017/18	2018/19	2019/20	2020/21 target
% older patients assessed for the risk of falling	76%	77%	52%	98%	90%
% older patients assessed as at risk of falling who received an individualised care plan that addresses these risks	77%	68%	75%	72%	90%

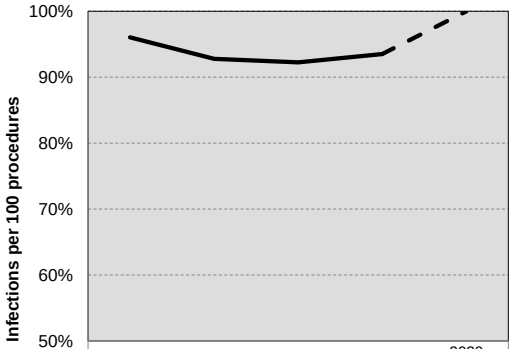
Percentage of opportunities for hand hygiene taken



	2016/17	2017/18	2018/19	2019/20	2020/21 target
% of hand hygiene opportunities taken	87.0%	86.3%	88.0%	85.0%	80.0%

% of hip and knee arthroplasty primary procedures where antibiotic given 0–60 minutes before 'knife to skin'

Replaces former measure of surgical site infections with this more comprehensive process one.



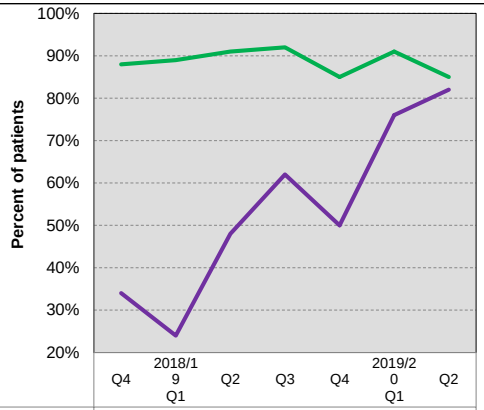
	2016/17	2017/18	2018/19	2019/20	2020/21 target
% of hip and knee arthroplasty primary procedures where antibiotic given 0–60 minutes before 'knife to skin'	96.1%	92.8%	92.3%	93.5%	100%

% of patients with early warning scores calculated correctly

% of patients who triggered an escalation of care and received the appropriate response

Measure has been in place for less than two years so it has been reported by quarter.

A national target does not exist yet.



	Q4	2018/19 Q1	Q2	Q3	Q4	2019/20 Q1	Q2
% of patients with early warning scores calculated correctly	88%	89%	91%	92%	85%	91%	85%
% of patients who triggered an escalation of care and received the appropriate response	34%	24%	48%	62%	50%	76%	82%

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://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/

Outputs

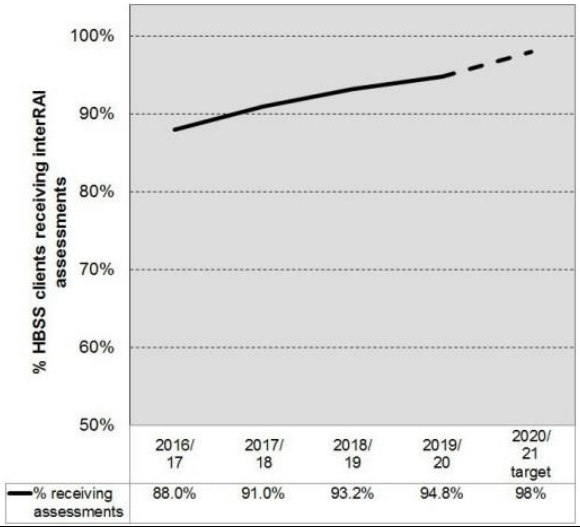
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Officer.

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

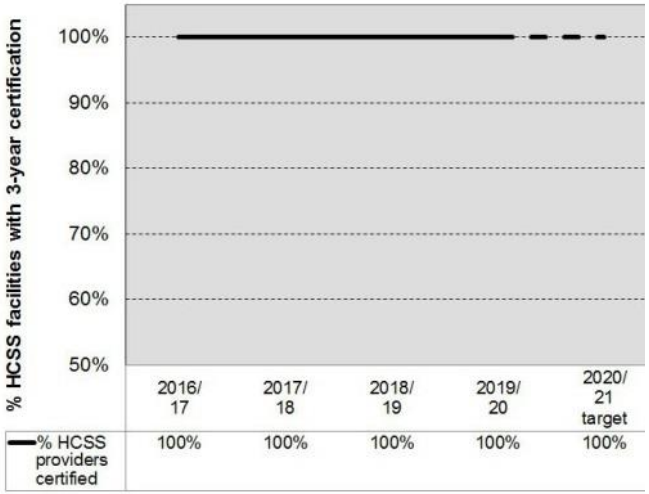
Good quality clinical assessment for older people who live at home helps them remain there. With the assistance of home and community support services they are more able to 'age in place' rather than enter supportive accommodation. This not only improves their quality of life but reduces pressure there will be on hospital and aged residential care resources.

Outputs

1,993 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 2019.

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.

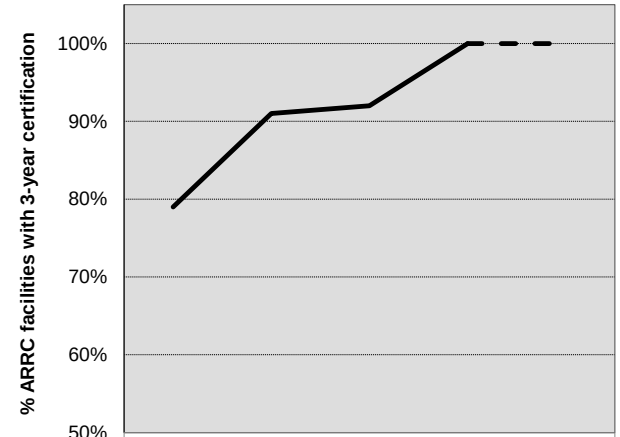
All NDHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2,633 people in the community up to Dec 2019.

Measure: % of ARRC providers with at least 3-year certification

Measure type: Quality



	2016/17	2017/18	2018/19	2019/20	2020/21 target
% with ≥ 3y certification	79%	91%	92%	100%	100%

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 2019/20 there are 24 facilities, of which 15 have 3-year certification and 8 have 4-year. One facility, which previously had 3 years certification, changed ownership in February 2020, and as a result has an automatic 1 year certification period. This facility has been excluded from this Indicator of ARC quality for 2019/20, as the sale process and change of certification is not related to audit results. 23/23 = 100% of facilities have certification 3 year or higher.

Statement of Financial Performance - By Output Class

	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Budget 2020/2021
	$000	$000	$000	$000	$000
DHB Provider Revenue	380,429	27,162	4,442	17,056	429,089
Other Provider Revenue	13,881	3,326	9,234	2,464	28,905
Less Revenue Offsets	(1,336)	(5,466)	(474)	(3,662)	(10,937)
DHB Funder Revenue	111,843	133,257	10,344	87,553	342,998
DHB Governance & Administration	0	0	0	0	0
Total SOI Revenue	504,817	158,280	23,546	103,411	790,054
Personnel Costs					
Medical Labour	83,269	7,303	1,163	105	91,840
Nursing Labour	103,335	9,570	1,448	6,140	120,494
Allied Health Labour	33,596	12,336	2,629	2,885	51,446
Non Clinical Support Labour	6,554	300	13	84	6,950
Management and Admin Labour	34,219	4,258	3,544	1,855	43,875
Non-Personnel Operating Costs					
Outsourced Clinical Services	14,583	1,946	590	379	17,498
Oth Clinical Supp	39,295	2,310	514	2,693	44,812
Implants	5,970	0	0	0	5,970
Pharmaceuticals	13,400	86	12	533	14,032
Infrastructure and Non Clinical	43,941	3,835	1,595	2,225	51,596
Cost of Capital	6,752	618	228	342	7,940
CTA Recoveries	(3,177)	(387)	(279)	(58)	(3,902)
Patient Support	5,101	12	0	35	5,148
Sterile Supplies	293	5	0	0	299
Provider Payments					
Personal Health	91,857	124,880	2,795	3,538	223,070
Mental Health	18,146	3,177	0	0	21,322
Disability Support Services	118	0	0	80,403	80,522
Public Health	0	0	420	0	420
Maori Health	0	6	6,690	0	6,695
Total SOI Operating Expenditure	**497,252**	**170,255**	**21,362**	**101,160**	**790,029**
Surplus (Deficit)	**7,565**	**(11,976)**	**2,184**	**2,251**	**24**

Appendix 2 System Level Measures Improvement Plan 2020/21

This SLM plan covers the requirements of the community part of 2.6.6 Acute demand and 2.7.1 Primary health care integration.

Introduction

In July 2019 a new and sole Primary Health Entity, Mahitahi Hauora, was launched in Northland.

The Mahitahi Hauora Board members are drawn from the NDHB, Iwi Health Providers, General Practice, Primary Care and Community.

This collaborative approach supports the commitment and determination to deliver a transformational strategy for Northland Healthcare. The Board of Mahitahi Hauora is a living embodiment of the Northland Alliance.

Mahitahi Hauora

Mahitahi board members

Geoff Milner (Trustee)
Acting Independent Chairperson

Dr Suzanne Phillips (Trustee)
Deputy Chairperson

Errol Murray (Trustee)

Lynette Stewart (Trustee)

Dr Andrew Miller (Trustee)

Dr Justine Woodcock (Trustee)

Moe Milne (Trustee)

Anthony Thompson (Trustee)

Dr Nick Chamberlain (Non-Trustee member) CEO NDHB

Development of the Mahitahi Hauora Strategy and Action Plan has required a different way of thinking and engaging with consumers, whānau, iwi, tertiary providers, and representatives from across primary, community and secondary care. This approach will be maintained through implementation and extended to include engagement with social and private sectors. There is a strong commitment to meet our Te Tiriti o Waitangi obligations and to achieve Māori health equity in Tai Tokerau/Northland.

Mahitahi Hauora has committed to achieving health equity for Māori across Northland by working in a collaborative and deliberate approach, innovation and transformation in service delivery, effective partnerships across health and social services, and through addressing what matters to whānau to achieve self-determined wellbeing. We are accountable to patients, whānau, and communities, and for improving Māori health outcomes. The SLM plan that has been produced is informed by significant engagement and consultation with providers; whānau; patients and clinicians.

Appreciative Inquiry hui have been held across Tai Tokerau. The process is a strengths-based way of building upon the many good aspects that already exist in human systems. It seeks to engage stakeholders in self-determining change, and identify opportunities for collaboration, establishing trust, and creating a shared sense of purpose and commitment. Localities were determined through mining of data to highlight inequities within the system across the life course of Northlanders.

Our strategic action plan has two key approaches set across the life course of individuals and whānau:

1) A portfolio approach of three key priority areas

- Mama, Pēpi and Tamariki 0-11years: Start Well.
- Taitamariki 12-24 years: Develop Well.
- Healthy Aging: Long term conditions and complex conditions: Age Well.

2) To use localities to incubate ideas, models of care and achieve outcomes. Learning, continuous improvement and collaboration across providers from the locality mahi will be used to inform progress and ensure we are accountable to our aims and objectives.

Benefits framework: A 2026 Northland healthcare system that sustains equitable self-determined well-being

	Whānau Knowledge	Whānau Health	Whānau Relationships	Whānau participation in community	Whānau engagement with Te Ao Māori	Whānau Living Standards	Whānau built natural environments
Whānau Ora Outcomes							
Strategic Focus	**START WELL** **Māmā Pēpi Tamariki** 'Māmā, pēpi and tamariki enabled to reach their aspirations of oranga'	**DEVELOP WELL** **Whakapiki ake Taitamariki** 'Resilient taitamariki'	**AGE WELL** **Healthy Aging** "Adults live healthy happy productive lives and age well in their own homes for longer"	**LIVE WELL** **Wellbeing Health Promotion** 'Building on whānau and community strengths to improve health equity'	**Accessible and Sustainable Primary Care** 'An engaged and responsive Primary Care workforce'		
LEADING THE WAY IN...	1. Achieving equity for Māori pēpi to be enrolled with a GP by 3 months of age 2. Increasing connectivity between health and social service providers	1. Engagement of taitamriki with Youth Workers 2. Enabling taitamariki independence to achieve life milestones that matter to them 3. Increasing taitamariki access to health & social services	1. Planning care that matters to adults 2. Saving the hearts of Māori men	Creating a thriving Northland for whānau to live and grow by: 1. Creating warm, dry, healthy homes 2. Increasing access to healthy kai 3. Supporting agency responsiveness to tamariki and taitamariki 4. Supporting Māori to stop smoking	1. Reflecting the population we serve 2. Implementing health equitable models of care 3. Building whānau capability to achieve wellness 4. Improving access to services		
Population focus	Pēpi and tamariki (0-12 years) in the far North: 0-4 yrs – 1637, 80% Māori 5-14 yrs – 3605, 79% Māori	7000 12-24yr olds, with a special focus on taitamariki Māori and those not enrolled in General Practice or a Health Clinic.	People who are frail (or close in age and interest), have complex needs and are high users of health services; and Māori men who work in or are enrolled in a practice within North Whangarei.	Māori whānau and hapori throughout Tai Tokerau.	Primary care workforce in Northland including GP's, Nursing, Allied Health, Māori Workforce, Non-regulated health, managers and administrators.		
Model of Care	Commencing with newborn enrolment, facilitate the development of a continuum of care model for all tamariki and work together with health and social service providers to deliver consistent support and a collaborative approach. Guide whānau, pēpi and tamariki through case conferencing/MDT using the whānau ora "Kaiarahi programme" navigators and/or health coaches. Promote healthy environments that support healthy kai, physical activity and effective weight management.	Recruit and assign Youth Workers to specific localities. These roles will sit in established Māori Health Providers and NGO's to support collaboration to improve access to health and social services enabling achievement with life passport milestones, drivers licensing and funded activities.	Coordinate multidisciplinary team meetings to coordinate care of highest adult users of health care. A navigation team will work to action outcomes/goals as identified by whānau and providers. Improve equity in heart health outcomes for Māori men through early detection of cardiovascular disease (CVD) and management of risk factors.	Utilise community development approaches and form intersectoral partnerships to deliver health promotion programmes that enhance determinants of health; Healthy Homes Tai Tokerau, Manawa Ora Healthy Homes Initiative, Kai Ora, Oranga Kai, Child and Youth Friendly Tai Tokerau. Work collaboratively with tamariki, taitamariki, whānau and communities to improve health equity, underpinned by Te Tiriti o Waitangi. Strive for Oranga Tamariki/Whānau/Tai Tokerau by celebrating communities strengths to improve wellbeing.	Explore and implement new models of care and build Northland workforce multidisapline pipeline. Launch a health and science academy for tauira Māori and second-chance learners with focus on micro-credentialing NCEA levels 3-5 combined with on the job learning. Partner with key stakeholders to establish rural health immersion hub with focus on growing Māori workforce. Provide workforce enablers; POADMS (primary options acute demand service), Neighbourhood Health Care Homes, Kia ora Vision, GP/ NP hubs / Locum co-ordination.		
Indicators	• Increase newborn enrolments • Increase utilisation of Whānau Tahi multidisciplinary model • Increase whānau access to tamariki nutrition and lifestyle support • Increase the number of tamariki enrolled in an Oral Health Provider • Improvement of health caused by environmental conditions – smoking and poor housing • Increase in connectivity between services and providers	• Youth workers have significant Involvement with taitamariki • Improvement in taitamariki experiences in education, employment and training • Increase in taitamariki in Quintile 4 & 5 passing their Learners Licence on first attempt • Increase in equitable taitamariki access to primary mental health and wellbeing services • Increase taitamariki engagement, leadership and capacity building	• Reduction in ASH rates and inequities attributable to CVD and diabetes • Improvement in CVD and diabetes indicators for Māori • Improvement of care processes for primary prevention of LTCs • Improvement in patient experience • Improved co-ordination of care via shared care plans and coordinators • Improved access to primary mental health and wellbeing services • Improved management of musculoskeletal conditions	• Increase number of Māori homes that are warm and dry • Increased production, availability and consumption of local, healthy, sustainable kai • Increase number of quit attempts for Māori • Improve stop smoking rates for Māori • Increased capacity of Northland Intersectoral Forum member agencies to respond in child and youth-centered ways • Increased capacity of youth workers	• Patients have access to GP services • Reduced burnout of GP workforce • Timely patient-centred urgent care in primary setting • Māori participation, retention and completion in level 3-5 health employment pathways • Equitable secondary education outcomes for tauira Māori • Improved patient experience • Reduced length of stay and ED presentations for specific conditions • Equitable uptake of shared care plans through Kia Ora Vision		
KEY MEASURE/S	**Increase enrolment of pēpi Māori through optimising connectivity between health and social service providers.**	**Taitamariki engaged by Youth Workers to achieve Life Passport Milestones.**	**10% reduction in GP visits and ASH admissions. Reduction in death due to heart attack/stroke in Māori men.**	**60% Māori households insulated and / or heated.**	**Increase Māori workforce** **All individuals, whānau have access to the right care at the right place at the right time.**		
Contributing Measures	• Increase from 81% to 95% tamariki Māori enrolled in General Practice by 3 months of age • Immunization increase at 6 months from 36% to 70% for tamariki Māori • Increase access to oral health services from 82 to 95% for tamariki Māori • Decrease from 4.6% to 3% in in ASH rates for tamariki Māori. (SLM Draft Improvement Plan • Increase from 76% to 90% tamariki Māori enrolled with a Well Child Provider by 3 months of age	• 70 taitamariki providing positive feedback of engagement with Youth Workers (Outcomes Rating Scale) • Taitamariki achieving in education, employment and training opportunities in each locality by 15% • 120 taitamariki enrolled with GP/Youth Health Clinics • 120 taitamariki have STI, ETOH & Drug Screening in achieving their Youth Passport Milestones • 35 taitamariki have Care Plans developed through Community Care Management (MDT) • Taitamariki Māori (20-24yrs) have reduced self-harm hospitalisations & short stay ED presentations	• Reduce ASH admissions from 34.8% to 24.8% • Reduce GP utilisation of 29697 by 10% • Improve pharmacological management of CVD for Māori men from 36.2% to 46.2%	• 80% of whānau Māori reporting home improvements • 95% Māori enrolled in stop smoking service make a quit attempt • 50% of Māori enrolled stop smoking • 75% of Kai Ora projects funded that impact Māori • 10 agencies that complete a child and youth friendly organizational audit • 60 of youth workers trained • 2 youth worker networks throughout Tai Tokerau	• Increase GP sessions over the next 12 months from average of 4-6 sessions to 6-8 sessions per week • Employ 1x locum GPs in 12 month/ Employ 1x locum NP in 12 months • Implement 2x positions health work based Training for Maori • 80% of 30 tauira Māori achieving NCEA L1 and Science • Increase KOV enrolment from 34% for enrolled Maori to 40% in total • Increasing from 70% patients triaged seen same day to 85% patients triaged seen same day Maori being a priority. • In line with KOV enrolment 40% having an active shared care plan • Reduce presentations to ED by 3% • Reduce the number of tamariki Māori aged 0-4 years ASH rates by 3%: • Diabetes HBA1C <64 increase from 40 to 60%. • CVD management from 48% on triple to 55%		

Ambulatory Sensitive Hospitalisations for 0-4year olds SLM plan 2020/2021

Reduced avoidable hospital admissions among children

See also 2.3.2 Maternity and early years action 2.

Current National Enrolment Service (NES) data illustrates the inequity for the rates of enrolment for Pēpi Māori compared to non-Māori. Stats as at September 2019 (first quarter) and December 2019 (second quarter):

Stats as at September 2019 (first quarter):

	Total popn. % enrolled	% Māori
At 6 weeks of age	77.1%	65.0%
At 3 months of age	94.3%	78.1%

Stats as at December 2019 (second quarter):

	Total popn. % enrolled	% Māori
At 6 weeks of age	74.0%	68.9%
At 3 months of age	85.7%	80.6%

Feedback from both whānau and providers stated a top-ranking issue was the disconnection between services and this has reiterated throughout the Appreciative Inquiry (AI) process. This disconnect has a direct detrimental impact on the continuum of care for individuals and their whānau due to the increased risk of gaps and duplication resulting in delays in accessing relevant services.

Findings from engagement and data analysis identified:

1 Lack of access and complexity of enrolment process. (Reviewing newborn enrolment data and other child health reports tells us that Tamariki Māori are less likely to have access to services compared to those of non-Māori.)
2 Whānau / Tamariki who are not enrolled in general practice are also more likely to have high rates of presentation to secondary care.
3 Whānau / Tamariki who are not enrolled in general practice are more likely to have missed opportunities for preventive care and early assessment and treatment of clinical issues.
4 Whānau who decline vaccinations are often those same Whānau / Tamariki who are not enrolled at general practice.

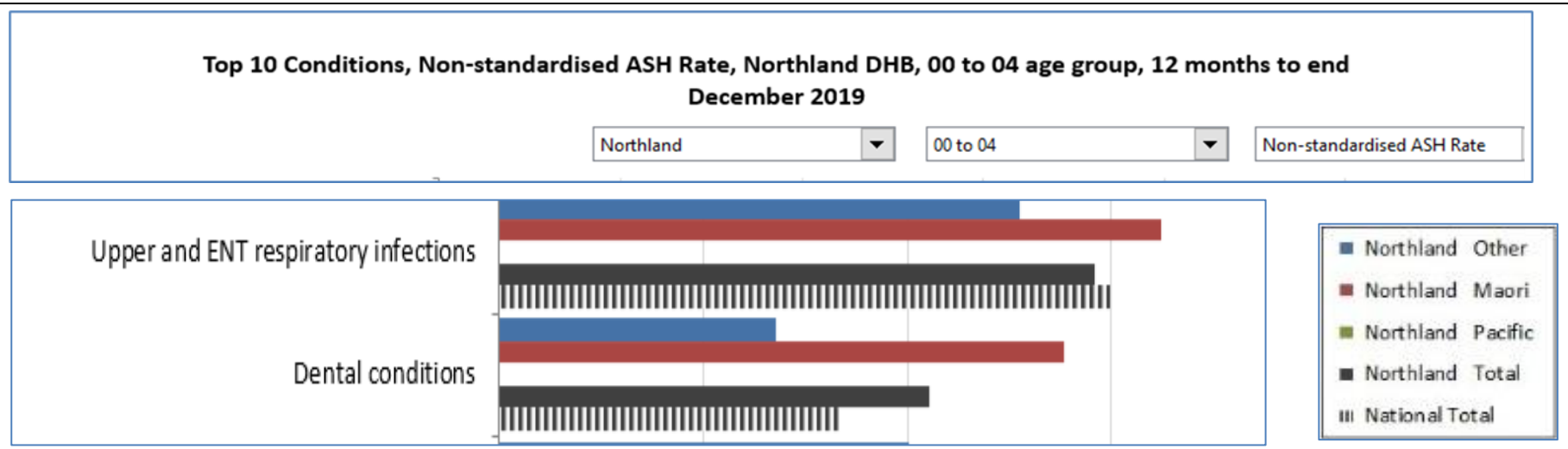
Mahitahi Hauora have identified a high priority group of Pēpi, within the geographical locality of Kaikohe, Kawakawa, Whangaroa (Kaeo), Morewa and Paihia *(Locality One).

Improving enrolment processes to mitigate current barriers and challenges for whānau enrolling newborns will enable Increased access to general practice and other primary health care services for Tamariki Māori.

Increased access to primary care will lead to:

- improved rates of Tamariki Māori fully immunised by 6 months, therefore reducing the risk of preventable diseases
- established relation between provider and whānau increasing access to acute care for Tamariki
- reduced gaps and duplication through increased connectivity between services and providers through MDT and other forums
- Improved Dental care access and reduction in ASH related dental admissions

Our hypothesis is that the introduction of these identified activities will reduce ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds as access to primary care services and timely interventions increase. The focus in this improvement plan is reducing the rate for respiratory and dental ASH, which will lead to an overall reduction in ASH rates for this age group.


Top 10 Conditions, Non-standardised ASH Rate, Northland DHB, 00 to 04 age group, 12 months to end December 2019
Northland
00 to 04
Non-standardised ASH Rate
Upper and ENT respiratory infections
Dental conditions
Northland Other
Northland Maori
Northland Pacific
Northland Total
National Total

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

Milestones	Activities	Contributory measures
Reduce ASH rate for tamariki Māori by 3%.	Continue the ongoing implementation of NCHIP and Te Māhuri Care connection process as per identified activity in 2019/2020 SLM Formulate a priority matrix for contacting Whānau with unenrolled Tamariki newborn to 3 months of age within Q1 and implement for our priority Populations* by Q4. Implement a pilot project initially in Mahitahi Hauora Locality One * that prioritises those Tamariki Māori with notified recurrent admission with identified ASH conditions to refer for proactive case management, through existing MDT processes. Initiate the resourcing and planning for the implementation of two projects within the Locality for Mama,Pepi, Tamariki as identified priorities * by Mahitahi Board, our Northland Alliance : • Start Well (Immunisation) and • Start Well (Oral Health) Projects	Increase Percentage of Māori infants in Northland enrolled in the Primary Health Entity by 3 months (from 80.6%) Number of Manawa Ora Healthy Home Initiative (HHI) referrals received and actioned for priority tamariki Number of tamariki Māori within our pilot locality One * admitted to hospital with identified recurrent ASH admissions who are subsequently referred for MDT proactive case management Rate of Tamariki Māori receiving immunisations by 6 months of age. Rate of Tamariki Māori receiving appropriate dental care before starting school.

Acute Bed Days SLM Plan for 2020/2021

Improved management of demand for acute care

There is an increasing burden of long-term conditions as well as a growing population of older frail people in Whangarei. Care coordination for people with complex needs is fragmented and is confusing and exhausting for the individual or whānau to navigate. Mahitahi Hauora employed a collaborative approach using the Appreciative Inquiry (AI) methodology for management of long-term conditions within the North Whangarei locality. As a result of these workshops, it was determined that supporting people with complex health needs to live well in their own homes for longer was a top priority.

This project will work on the following problems being experienced by individuals who are high users of the health system:

- high readmission rate
- duplication/absence of service delivery
- delay in appropriate service delivery/treatment
- fragmented care
- high cost of people going into residential care facilities
- inequitable service provision for priority populations.

These challenges contribute to early death, increased system level demand through service usage, increased strain on physical and financial resources and poorer health outcomes and quality of life for these people. In addition, Appreciative Inquiry workshop findings have pointed to clinical stress and job dissatisfaction due to inability to fully meet the needs of complex patients.

Northland is experiencing a significant increase in population. Coupled with our aging workforce and ever-increasing demand on access of health services, it is putting the system under significant strain:

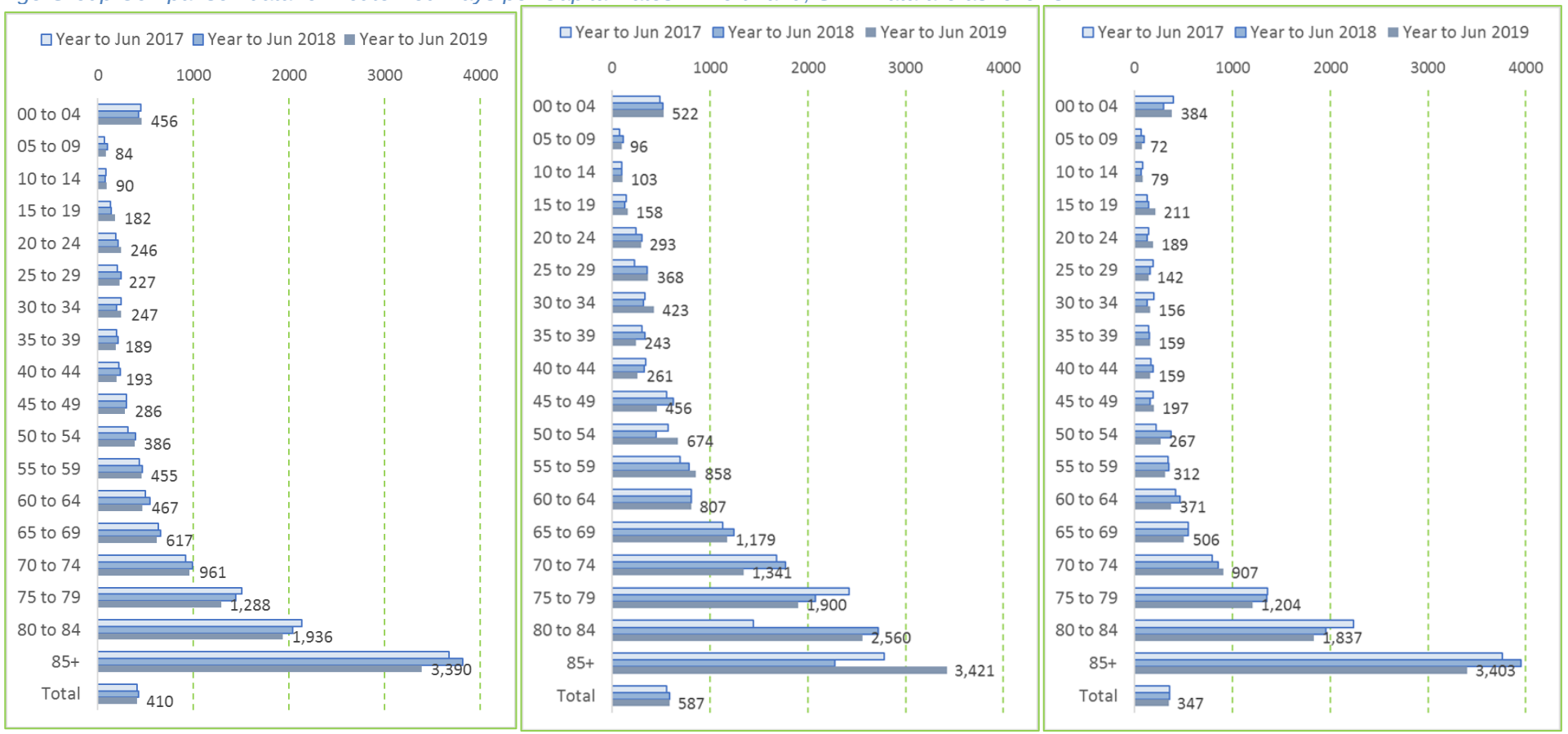
	Census Year	Age																				
		Total	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99	100+
Total population	2018	179,076	11,682	13,359	12,579	10,494	8,520	9,822	9,513	8,751	9,600	11,649	12,345	13,239	12,495	11,724	9,456	6,507	3,831	2,271	993	216	21
	2013	151,689	10,659	11,019	11,070	9,627	7,056	6,657	6,591	7,899	9,834	10,629	11,502	10,914	10,464	9,333	7,269	4,836	3,399	2,004	753	147	24
5 year growth		18.05%	9.60%	21.24%	13.63%	9.01%	20.75%	47.54%	44.33%	10.79%	-2.38%	9.60%	7.33%	21.30%	19.41%	25.62%	30.09%	34.55%	12.71%	13.32%	31.87%	46.94%	######
Māori population	2018	64,458	6,582	7,446	6,645	5,469	4,206	4,320	3,708	3,219	3,366	3,825	3,795	3,720	2,784	2,169	1,422	960	507	240	69	9	0
	2013	44,931	5,145	5,022	4,974	4,032	2,853	2,388	2,178	2,460	2,697	2,850	2,913	2,247	1,725	1,287	1,005	648	339	132	33	6	3
5 year growth		43.46%	27.93%	48.27%	33.59%	35.64%	47.42%	80.90%	70.25%	30.85%	24.81%	34.21%	30.28%	65.55%	61.39%	68.53%	41.49%	48.15%	49.56%	81.82%	109.09%	50.00%	######
Non-Māori population	2018	114,618	5,100	5,913	5,934	5,025	4,314	5,502	5,805	5,532	6,234	7,824	8,550	9,519	9,711	9,555	8,034	5,547	3,324	2,031	924	207	21
	2013	106,758	5,514	5,997	6,096	5,595	4,203	4,269	4,413	5,439	7,137	7,779	8,589	8,667	8,739	8,046	6,264	4,188	3,060	1,872	720	141	21
5 year growth		7.36%	-7.51%	-1.40%	-2.66%	-10.19%	2.64%	28.88%	31.54%	1.71%	-12.65%	0.58%	-0.45%	9.83%	11.12%	18.75%	28.26%	32.45%	8.63%	8.49%	28.33%	46.81%	0.00%

This data clearly demonstrates the impact of the growing population trends across Northland. Northland is also experiencing severe GP shortages which is resulting in more and more pressure on walk in services such as urgent care centres and ED centres. Managing the impact of Long-Term conditions, as well as identifying opportunities to improve patient flow throughout the system continues to a be a significant priority.

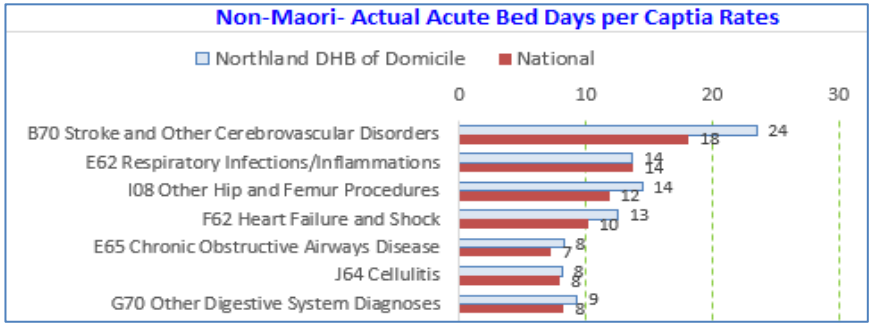
There is significant evidence to suggest that providing shared care platforms through Multidisciplinary Teams (MDT) provides patients with the confidence to

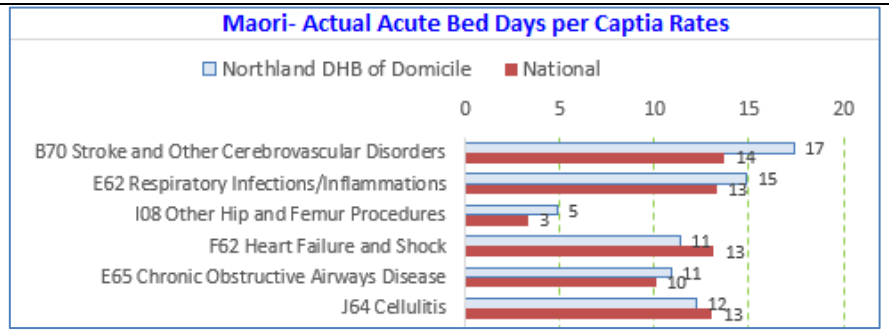
manage their condition at home, reducing the need for unplanned admission and presenting to urgent care facilities.

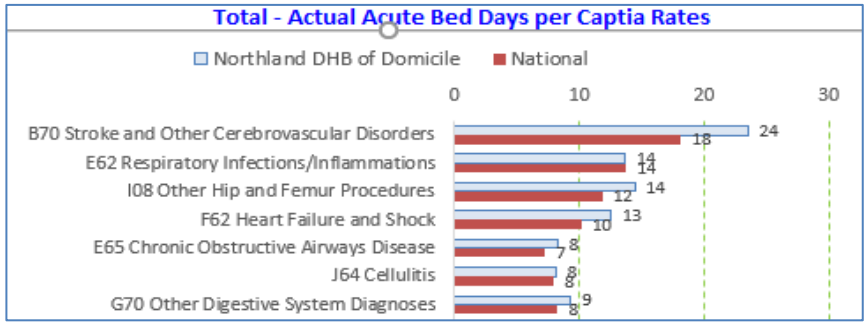
Age Group Comparison data for Acute Bed Days per Capita Rates in Northland, SLM Data are as follows:



Review of the actual acute bed day data on condition by condition basis shows the following:







The DRG codes suggest that primary care can make impact in the ABD rates for Māori respiratory conditions, cellulitis and COPD.

The reality of the situation is clear: Northland must innovate models of care than enable people to live well in their own communities, to have access to high quality primary care, and to support the development and resilience of primary and community providers to meet the rising demand. This is particularly evident for Māori who are the single largest growing population and are disproportionately overrepresented in acute bed day stays in all categories across the life span.

Mahitahi Hauora has a significant investment strategy to look at upstream workforce programmes which look to increase access to clinical teams and grow capacity in the primary care system. Our immediate focus in this plan is to provide models which can help us to manage the current levels of demand and ABD rates.

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

Milestones	Activities	Contributory measures
Reduce the equity gap by 10% between Māori and non-Māori in the number of actual acute ASH rates[6] by June 2021:	Target top 100 patients with complex needs that are high users of secondary care and are amenable to primary care intervention: Coordination of individual packages of care by POADMS, including active pull from wards for amenable early discharge. COPD winter rescue packs. Implement Multidisciplinary Team meetings to address complex management across cross sectoral health providers focused on improving management in primary care settings.	Acute bed days saved in respiratory conditions, Stroke and COPD. Reduction in average LOS Māori Reduction in ASH rates Māori Reduction in ASH events Māori

[6] For Whangarei Hospital

Amenable Mortality SLM Plan for 2020/2021

Prevention and early detection

Draft Amenable Mortality DHB summary 2016 (NSFL), DHB of domicile Northland:

	2009		2010		2011		2012		2013		2014		2015		2016	
	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate	Deaths	Rate
Māori	146	323.1	121	253.8	132	280.7	140	284.6	135	253.1	116	210.9	115	211.8	126	220.3
Pacific	4	…	7	…	3	…	1	…	5	…	5	…	3	…	6	…
Non Māori, Non-Pacific	158	102.7	170	98.4	166	97.7	181	96.1	148	75.6	153	84.3	159	74.6	191	97.1

Rates per 100,000 age standardised to WHO world standard population. Rates are suppressed where there are less than 30 deaths

In Northland, the 2 leading causes of Amenable Mortality in Northland are Diabetes and CVD related conditions.

Amenable mortality deaths, 0-74 year olds, 2010-2016:

	2010	2011	2012	2013	2014	2015	2016 (provisional)
Diabetes	26	25	25	21	20	17	30
Valvular heart disease	7	10	7	5	10	9	9
Hypertensive diseases	3	5	4	3	2	7	3
Coronary disease	84	88	87	86	73	71	69
Heart failure	2	3	1	2	2	0	1
Cerebrovascular diseases	22	22	17	22	25	27	28
Pulmonary embolism	1	1	1	0	1	0	2

Atrial fibrillation and flutter	2	1	2	4	5	4	5
COPD	32	24	31	19	25	38	35

Approach to CVD

In 2018 the Ministry of Health consensus statement recommended that all Māori should have a CVD risk assessment at a younger age; 30 years for Māori men and 40 years for Māori women.

A number of collaborative workshops were conducted within the North Whangarei locality using the Appreciative Inquiry methodology. As a result of these workshops it was determined that reducing premature death of Māori men was an immediate priority.

Overall, Māori are more than twice as likely as non-Māori to be hospitalised, and two and-a-half times as likely to die from cardiovascular disease CVD (Ministry of Health). Māori are also less likely to access health care and do not receive the same level of referrals and specialist care as non-Māori. Māori are more than twice as likely to have gone without health care in the past year due to significant barriers such as cost.

In Northland there are 40,984 men eligible for CVRA; of these eligible men 10,620 are Māori. To date there have been 8,418 Māori men screened. The screening uptake is high but management of heart health risk greater than 15% needs significant improvement:

- current rates for dual therapy are 21.1% for those with a risk of 15-20% and 35.9% for those with risk >20%
- current rates for prior CVD on triple therapy are 48.0%.

In 2018/19 the Northland Alliance conducted a Point of Care testing pilot at AFFCO Moerewa, as part of SLM long term conditions CVRA screening, focused on HbA1c testing.

The predominant ethnic group was Māori 64.9%. 56 (98.3%) of the participants completed questionnaires which were designed to assess their impressions and gain feedback about the study. The results showed 98.3% participants would recommend this programme to their family, whānau and work mates and 98.3% would participate if it was repeated in 2020.

A paper has been published on the research from this project. It is with this learning in mind, alongside The Heart Foundation Māori men co-designed heart health work, that Mahitahi Hauora will implement Heart Health Hauora Ecosystem Popup Clinics.

Approach to diabetes

Select DHB of Domicile:	Northland		Period	Q2 2019-20 to 31-Dec 2019

SS13 Improved management for long term conditions (Diabetes)

Numbers of people with diabetes

PHO register total (all PHOs) as at 31-Dec 2019			VDR estimate of diabetes prevalence as at 31 Dec 2018			Estimated completeness of diabetes ascertainment by PHOs		
Denominator								
	Ages 15-74 only	All ages		Ages 15-74 only	All ages		Ages 15-74 only	All ages
Maori	3,641	4,150	Maori	4123	4,719	Maori	88.3%	87.9%
Pacific			Pacific	201	223	Pacific	0.0%	0.0%
Other	3,750	5,394	Other	4368	6,377	Other	85.9%	84.6%
Total	7,391	9,544	**Total**	8,692	11,319	**Total**	85.0%	84.3%

HbA1c measurement data- for people aged 15-74 years inclusive

Numerator						
	Number with HbA1c ≤ 64mmol	Number with HbA1c > 64 mmol and ≤ 80mmol	Number with HbA1c > 80mmol and ≤ 100mmol	Number with HbA1c > 100mmol	Total number with any available HbA1c result	Total number with no available HbA1c result
Māori	1,346	501	363	182	2,392	**1,249**
Pacific					0	**0**
Other	2,263	605	263	70	3,201	**549**
Total	**3,609**	**1,106**	**626**	**252**	5,593	**1,798**

Percentage rate based on total PHO/practice count rate						
	% HbA1c ≤ 64mmol	% HbA1c ≥ 65mmol and ≤ 80mmol	% HbA1c > 80mmol and ≤ 100mmol	% HbA1c > 100mmol	Percentage with any available HbA1c result	Percentage with no available HbA1c result
Māori	**37.0%**	**13.8%**	**10.0%**	**5.0%**	**65.7%**	**34.3%**
Pacific	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Other	**60.3%**	**16.1%**	**7.0%**	**1.9%**	**85.4%**	**14.6%**
Total	**48.8%**	**15.0%**	**8.5%**	**3.4%**	**75.7%**	**24.3%**

There are approximately 1,7757 people living with diabetes who are unknown to the Northland health system.

Northland's Māori are significantly disproportionately affected by diabetes.8

Only 75.7% of Northlanders living with diabetes have an HbA1c recorded, 34.3% of Māori with diabetes have not got an HbA1c recorded, compared to 14.6% non-Māori.

There is a significant equity gap between Māori and non-Māori for patients with good control of 23%.9

Of the diabetic-related amputations in 2017/18, 44%10 were undertaken on Māori.

Effective primary and community care is widely accepted as being a critical enabler to support individuals living with diabetes to self-manage and improve their overall health and wellbeing outcomes. Mahitahi Hauora has made a commitment to prioritise funding to achieve health equity for Māori by:

- ensuring that the Cardiovascular Disease Risk Assessment for Primary Care guidelines are met and implemented
- that patients who have elevated risk for CVD are effectively prescribed triple and dual therapies on an equitable basis for Māori

that patients who live with diabetes have appropriate support to live well with diabetes and manage their condition well in the community.

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

Milestones	Activities	Contributory measures
Reduce amenable mortality for Māori Men by 10% by June 2023.	Provide Hauora ecosystem CVD clinics across multiple employers and community sites for the North Whangarei locality population. Develop, trial, refine and implement a pathway within the North Whangarei Locality to increase engagement for Māori men to optimise dual and triple therapy for CVR management by end of Q3. Development of a whole sector Northland Diabetes plan, utilising a co-design methodology by end of Q2. Socialise the Northland Diabetes plan across Northland by end of Q4.	Number of people seen in Hauora ecosystem heart health clinics Uptake of pharmaceutical dispensing of diabetes medication for Māori men with diabetes and prior CVD Uptake of pharmaceutical dispensing Dual/triple therapy for Māori men with prior CVD Number (and Percentage) of Māori with HbA1c<64mmol/mol Number (and percentage) of Māori with known

[7] MoH Virtual Diabetes Register predicts 11,319 people in Northland with diabetes: 9,544 in Northland have been diagnosed.
[8] 43.4% of the diagnosed population are Māori, against an overall Māori population of 34.2%.
[9] 1,346 Māori patients aged 15-74 (37%) had HbA1c result of under 64mmol/mol compared to 2,263 (60.3%) non-Māori. 1,046 Māori had HbA1c of 64mmol/mol or more compared to 938 non-Māori.
[10] National Minimum Data Set

		diabetes completing an annual Hba1c Number of mobile providers across Northland trained to use new pathway.

Patient Experience of Care 2020/2021

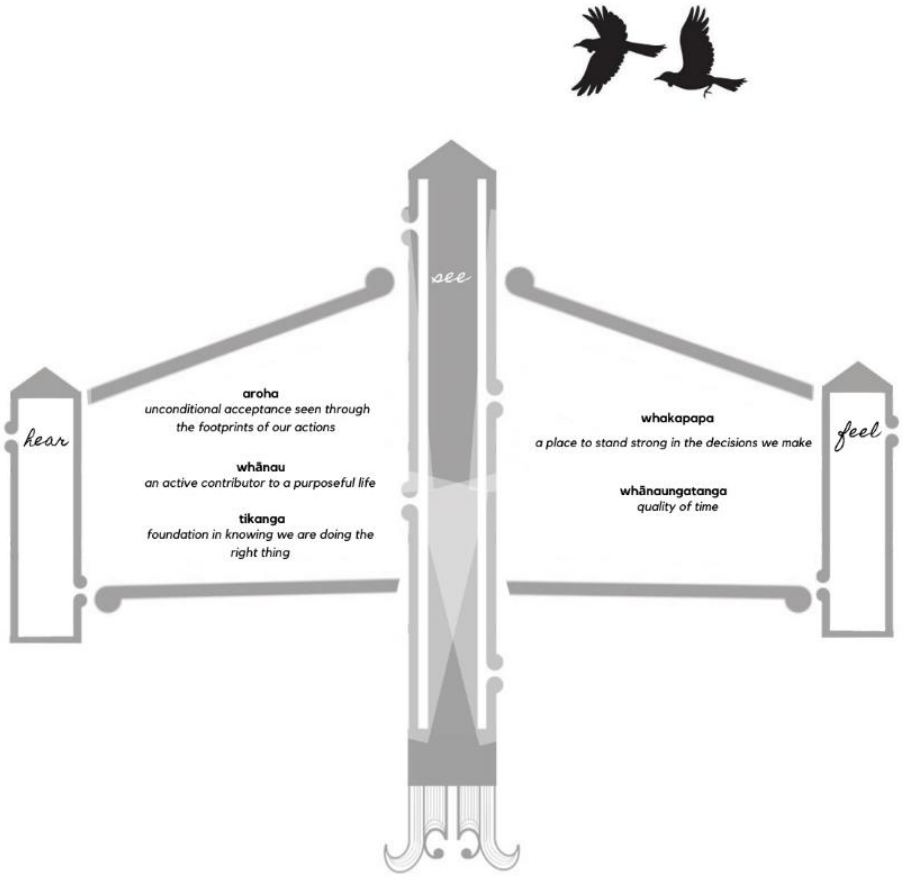
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

This SLM is described as “patient experience of care using the [Health Quality and Safety] Commission’s national adult hospital and primary care patient experience surveys”. Improvement milestone and activities for this SLM should focus on:

- questions that highlight inequities for Māori, Pacific and other high priority populations
- groups of questions in the domains that highlight an issue such as access to services, health literacy, medication reconciliation and adherence, flow of information between PHO/ practice to specialists or hospitals
- low scoring questions from the adult inpatient survey.

It must be acknowledged that the Commission’s national patient experience surveys are both under review and there has been a change of host provider. The reporting portal that has been used since inception of the national patient experience surveys closed on 30 January 2020, and a new portal is under development. The questionnaire itself is being refreshed, meaning that the old and new data sets will not be comparable.

At its essence, a patient experience survey informs planning and clinicians in the way they can deliver health care services in a more meaningful to patients. In a westernised world perspective, the models of engagement for surveys work relatively well However listening to the Māori community, we know that these methods are less effective at understanding their experience of care. Coupled with this, the infrastructure and delivery models for the surveys is predominantly via electronic collection.



what matters to whānau measurement papa tikanga

While western measures focus on physical outputs and outcomes, the What Matters to Whānau papa tikanga is measured by how whānau experience the tahā principles within an environment or context. Within a provider environment for example, we create experiences that enable whānau to hear, see and feel the things that matter to them. These are portrayed as a dual-axis measurement papa tikanga with an initial set of experience measures which will continue to evolve as this work progresses.

what matters to whānau tahā

	aroha *unconditional acceptance seen through the footprints of our actions*	*whānau* *an active contributor to a purposeful life*	*tikanga* *foundation in knowing we are doing the right thing*	*whakapapa* *a place to be strong in the decisions we make*	*whānaungatanga* *quality of time*
hear *how do whānau hear the tahā*	Whānau hear Te Reo Māori in the right context and natural form; correct pronounciation of their name and place names Whānau hear mana enhancing language when interacting with providers e.g. what matters to you vs. what's the matter with you	Whānau are connected and safe when service providers confidently use both te reo Māori and English Whānau voice is heard authentically developing trust and unity	Whānau values are acknowledged Whānau have a positive relationship with Te Ao Māori Whānau world view and context is acknowledged and sought for holistic understanding	Whānau can access and express their lineage, ancestry, descent, parentage culture and identity in ways that are meaningful to them Whānau whakapapa and talents are acknowledged and understood with authentic interest	Whānau are engaged in a process of relationship building (whānaungatanga) Whānau and providers work together to increase wellness for the whānau Whānau are listened to actively, without judgement
feel *how do whānau feel the tahā*	Whānau are acknowledged with a smile, hongi, warm gestures, body language or cues and a warm hand shake which makes them feel not alone in the process Whānau wellbeing is promoted through processes of powhiri (welcoming), karakia (prayer), kai (food) & hospitality Whānau are offered food, water or something else when a need needs to be met	Whānau feel empowered and valued when their voice and work is heard, noted and utilised developing a plan with whānau Whānau are working together and everyone has a place and identity and feel welcomed Whānau share common goals and everyone that is important to the individual is included	Whānau feel respected and are talked 'to', not 'at'. Whānau are engaged through a culturally safe process and correct protocol is followed Whānau opportunities are created for inter-generational transfer of knowledge & experience	Whānau identity with places of importance is acknowledged e.g. ko au te whenua, te whenua ko au (I am the land and the land is me) Whānau skills are acknowledged, strengthened and maintained when delivering service Whānau are supplied with resources to support and sustain their interests	Whānau wellness is enhanced through collaborative efforts directed by whānau Whānau are known personally by providers Whānau and community champions are identified and utilised to increase authentic and positive narrative about Māori in public messaging
see *how do whānau see the tahā*	Whānau see providers working alongside them which nurtures their wairua (spirit) by allowing whānau to create their own pathways	Whānau perspective of wellness is acknowledged, even if different from your own Whānau are not viewed or defined by their illness	Whānau see providers acknowledge tuakana, teina role - a reciprocal teaching and learning relationship between two people Whānau are given space to exercise leadership in Te Ao Māori	'Registering' whānau is not confined to service providers but can also include marae, iwi, community groups, local businesses, rugby, hunting & fishing	Whānau rangatiratanga (self-determination) flourishes when whānau are in control and leading the way for their whānau, hapu, iwi Whānau are offered both te ao Māori and Western options as choices of wellness

Northland is a highly rural and deprived population, with Māori overrepresented in the rural and remote communities, it can be argued they are offered less access to contribute to the surveys. This is reflected in the lower response and completion rates for Māori.

Mahitahi Hauora has developed an engagement framework that will support engaging with Māori whānau from a Te Ao Māori perspective. The Whānau Wellness Papa Tikanga approach (see pictorial above) describes our commitment to engagement and is a leading edge kaupapa to give voices to whānau and Māori communities across Tai Tokerau.

While the current health system is determined by western approaches that treat individuals, symptoms and disease using conventional medicine and mainstream methods, it is important to acknowledge the unique contribution Māori Provider communities contribute to transforming care delivery through operating in an inherent paradigm of Taonga tuku iho (traditional healing systems handed down over generations).\

Inpatient Survey

System level outcome: delivering patient centred care.

Rationale:

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Northland DHB has actively participated in the design of the revised national inpatient survey due for release in August 2020.Historically there has been a poor uptake of the national survey in Northland. For this reason, we have augmented uptake using an in-house survey based on a subset of the national inpatient survey questions.

Patient feedback is used widely throughout the organisation by way of consumer council participation in advisory groups, patient compliments and complaints and national and various in-house surveys that incorporate the patient experience when measuring service redesign. The in-house survey based on the national survey translates into publicly displayed ward posters that incorporate both qualitative and quantitative feedback and benchmarking. These posters are shared across all levels of the organisation from board to ward. Feedback to all levels of the organisation will in 2020-21 include equity reporting and the inclusion of the bias experience feedback from patients.

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

Milestones	Activities	Contributory measures
Primary Care survey Reduce inequities in self-determined wellbeing by increasing the number of Māori who are involved in decisions regarding their own care by June 2021. • Achieve at least 5% increase in positive responses from Māori patients to the survey question "Did the healthcare professional involve you as much as you wanted to be in making decisions about your treatment and care?"	Work with practice staff to improve access to programmes that can empower self-determined wellbeing for Māori. • Improvement Partners (formerly practice facilitators`) to encourage practices to meet their Kia Ora Vision enrolment and Whānau Tahi Patient Centred Care Plan targets for Māori patients with long term conditions through identifying enrolled Māori without current or up-to-date care plans using risk stratification tools. Then meeting with practices to create an action plan to improve, including working with the wider workforce (eg HIPs) and other providers (eg iwi and Māori providers). • Educate staff on the importance of the PE Survey and promote positive communications about it to patients through highlighting the survey at monthly practice managers' meetings and seeking ideas on how they will work with their staff, or what support they require, to highlight importance. Improvement Partners will also discuss with practice staff prior to quarterly surveys.	• Enrolments rates in Kia Ora Vision for Māori • Rates of Māori with LTCs have been involved in creating their Whānau Tahi Shared Care Plan • Number of Māori patients who accessed their Care Plan Achieve at least 5% increase in positive responses from Māori patients to the following survey questions;" ○ *Do you have a shared treatment or care plan agreed with a healthcare professional to manage your condition(s)?*" ○ *Did the healthcare professional involve you as much as you wanted to be in making decisions about your care and treatment?"*
Inpatient survey A 3 % improvement on the question 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?' by 30 June 2021.	Add national survery medication questions to the local inpatient survey. Use patient experience results for medication questions to inform the patient experience dimension currently absent in medication administration audits. Add patient experience quarterly survey results to quarterly consumer council agenda. Consumer council input on all patient facing documentation to ensure health literacy lens applied. Pilot of the Falls Assessment Form to include polypharmacy prompt for pharmacy review and whānau discussion on side effects to watch out for with identified at risk patients.	Number of advisory groups the consumer council participate in. 5% reduction in number of medication related falls during inpatient stay.

Youth Health SLM Plan for 2020/2021

Youth are healthy, safe and supported

Through the appreciative inquiry process undertaken in the Whakapiki ake Taitamariki locality, taitamariki, services and communities expressed the need for more youth workers to provide facilitation and connection to health and social services as well as regular activities such as sports, arts as designed by taitamariki. Taitamariki describe the need for 'youth appropriate access' enabling successful navigation and participation in the community to achieve life's transitions.

3 key priorities were identified by youth across Bream Bay, Onerahi, Raumanga and Dargaville:

- variable access to health, education, employment and recreational opportunities
- barriers of distance or rurality, creating disincentives for acquiring life passports and participating in recreational activities
- ability to exercise autonomy is restrained by the availability and access to support service options.

The extent of these problems is further supported by the following statistics identified in the Health Needs analysis for Te Tai Tokerau:

- for those 2-14yrs 4.4% were diagnosed with emotional or behavioural problems (5.5% for Māori & 3.2% for Non-Māori) and higher for males
- 20% of the Northland population >15years had a mood or anxiety disorder diagnosed which is one of the highest rates in New Zealand
- 8% of Northland adults scored highly on the Kessler 10 score, indicating psychological distress and a high probability of anxiety/depressive disorder. The 15-24-year age group were the most likely to score highly (10% of Tane).

There is a significant opportunity to collaborate with the community supported by the findings of the Mental Health review, which indicates a willingness to correct issues impacting on emotional well-being. Significant benefits for taitamariki in the areas of improving access to recreational services, reducing depression and increased emotional wellbeing can be achieved. Our goal is that taitamariki have access to their choice of experiences required for health and wellbeing as they transition into adulthood.

We have selected the Mental Health and Wellbeing domain to measure the impact of our plan. Young people experience less mental distress and disorder and are supported in times of need as measured by Self-harm hospitalisations and short stay ED presentations for <24 year olds. Our data set will be the PHO level data for the specific age group of10 -24 year olds and 20 to 24 year olds, which as at end of March 2020 is as follows:

Ethnic Group Analysis:

Self Harm Hospitalisations - Total <= Select Self Harm Hospitalisation Classification

20 to 24 <= Select Age Group

Total <= Select Gender

Report for Patient PHOs, March 2020

Ethnic Group Data - Youth Self Harm Hospitalisation Rates (per 10,000 population)

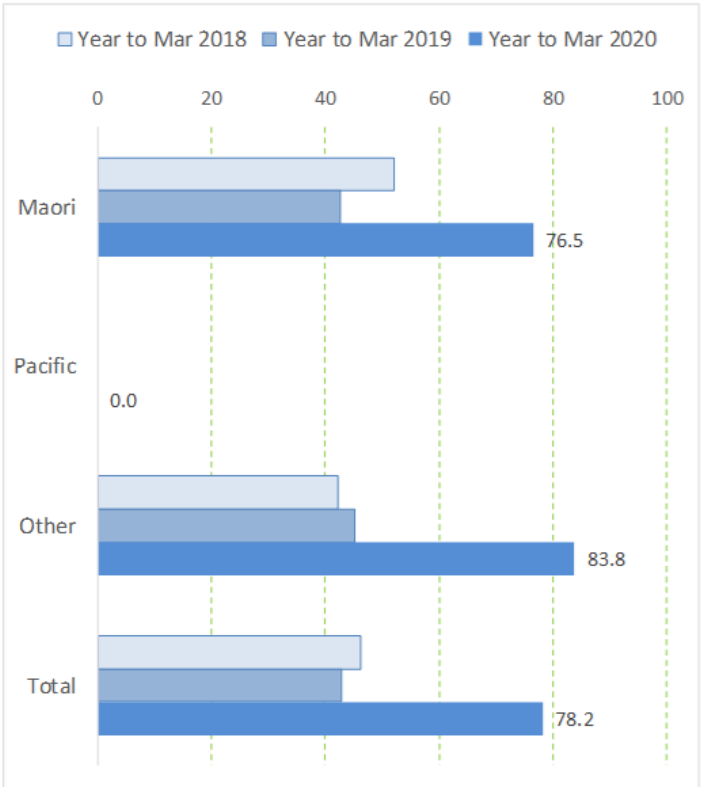
Using Standard Population: Census 2013 Usual Resident Population

Te Kaupapa Mahitahi Hauora

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	Year to Mar 2020	Year to Mar 2020	Year to Mar 2020	Year to Mar 2018	Year to Mar 2019	Year to Mar 2020
Maori	4,315	33	76.5	52.1	42.6	76.5
Pacific	183	0	0.0	0.0	0.0	0.0
Other	3,940	33	83.8	42.3	45.2	83.8
Total	8,437	66	78.2	46.2	42.9	78.2

Age Standardised Youth Self Harm Hospitalisation Rates

Te Kaupapa Mahitahi Hauora



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

Milestones	Activities	Contributory measures
5% reduction in Age Standardised youth self -harm hospitalisation rates by 30 June 2020.	Workforce training –MH Credential for all those working with youth, evidence-based and equity focused. Workforce training – MH:101 Employ and follow up with Induction training 5 youth workers. All Youth and PMH workers report monthly on incidence of Self Harm. Trial 10 x Community Care Management (CCM)/Multidisciplinary Team Meetings (MDT) Taitamariki engaged with youth and PMH workers have pre and post-depression and anxiety screening scores Taitamariki engaged with youth and PMH workers have Care plans	Number of workers trained MH Credential Number of workers trained MH:101 / Health literacy Induction training completed for all new Youth workers Monthly reporting demonstrates trends of Self Harm and promotion/ prevention activities Report monthly on CCM/MDT meetings Number of referrals of vulnerable youth to primary mental health services 80% Taitamariki engaging primary mental health support show an improvement in post screening scores (e.g Kessler 10) 80% Taitamariki complete Care Plans developed through Community Care.

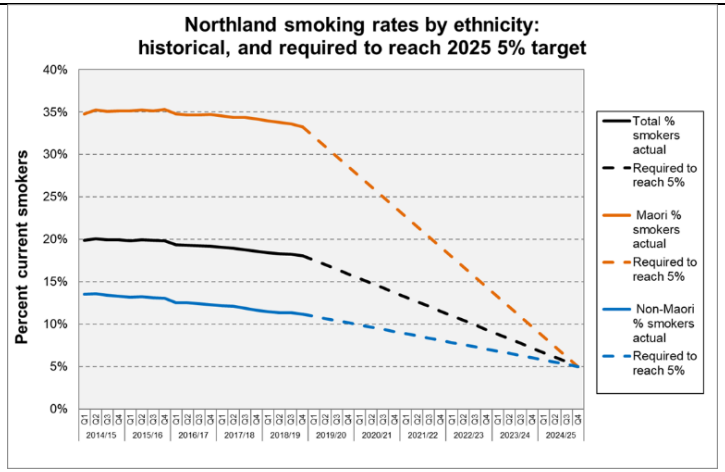
Babies Living in Smoke Free Homes SLM Plan for 2020/2021

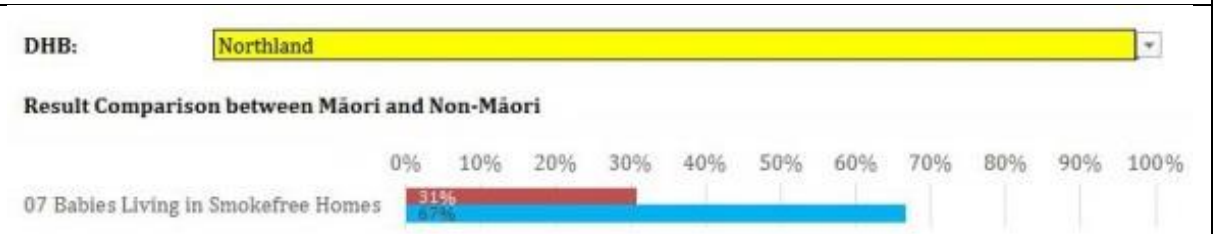
A healthy start

Tamariki across Northland are living in environments which are not compatible with health, including damp, cold housing or whānau who smoke cigarettes, with a significant equity gap for Pēpi Māori versus non-Māori pēpi:

Only 31% of Māori babies are living in smokefree homes compared to 69% for non-Māori – an equity gap of more than 30%. As the newly available data from the Well Child Tamariki Ora question set becomes available, we will link this directly to evaluating our approach to increase the number of Māori pēpi living in smoke free homes.

The graph below shows Northland smoking rates by ethnicity[11] and what will be required to meet the target of 5% across all ethnicities by 2025.





Significant additional effort, over and above current service delivery, is required to prioritise and support Māori to stop smoking, with a significant push to support hapū mama to quit.

From 1 July 2020 Mahitahi Hauora will implement a new model will implement a new model for Support To Stop Smoking within certain General Practices across Tai Tokerau. Within this model three levels of service were proposed. 13 practices have been contracted with to provide Support to Stop Smoking with a priority on hapū mama and wāhine Māori. For further details of the service levels please see attached (**Appendix A**).

[11] Data source is 'current smokers' out of the primary care smokers Quarterly Report to Northland DHB. We will use the newly available data as our baseline when it is available to us.

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

Milestones	**Activities**	**Contributory measures**
Rate of smokefree homes for Māori pēpi has increased from 27.8% to 35% by June 2021	Implement the new model of Support to Stop Smoking within general practice. Incentives (Warehouse vouchers) to stop smoking will be offered to hapū mama and wāhine Māori. Stop smoking attempts will be validated through CO monitors at 4 and 12 weeks post quit date. Engage with whānau and hapū mama to inform new models of care that lead to increased quit rates of hapū mama. Evaluate and refine the model using continuous quality improvement methodology. At level two practices will be incentivised to refer to Toki Rau (community-based stop smoking providers). Work with Toki Rau providers and GPs to embed feedback loops so that outcomes are shared and referrals increased.	Priority groups enrolled in service # and % Total # and % of Māori # and % of hapū mama # and % of parents Priority groups that make quit attempt # and % total # and % of Māori # and % of hapū mama # and % of wāhine Māori Priority groups that stop smoking at follow up CO validated # and % all population # and % of Māori Satisfaction surveys reviewed regularly for quality improvements # and % of surveys completed, total and Māori # and % of people satisfied or very satisfied, by total & Māori # and % of people who would return to service, by total & Māori # and % of people who would recommend service, by total & Māori Number of referrals from General Practice to Toki Rau.
	Improve the quality of data collection on smoking status of households for infants at six 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 Kaitaiki role support to LMCs and Well Child /	2% reduction of unknown's responses 5% increase of enrolment of Māori to Toki Rau Stop Smoking Services

	Tamariki Ora providers to increase the number of referrals for their clients to quit smoking services.	
	Implementation of hapū mama and whānau wellbeing wānanga "Whaia Te Ora" – focus on wellbeing with the overall goal of whānau working towards a quit smoking decision. Based on the Māori creation narrative following the same journey as Hine Kopu. Referrals to Whaia Te Ora will predominately be via Hine Kōpū with other options being explored from secondary care.	Number of referrals for hapū mama and whānau to Toki Rau following attendance at Whaia te Ora

Appendix A.

The previous 'opt out' model applied by Mahitahi Hauora to general practices has been changed to an 'opt in' model. There are three levels of service that general practices can opt in to, as described below:

Level 1:

- Supply of Nicotine Replacement Therapy (NRT) to patient
- There is no contract for service, just informal agreement the general practice will distribute NRT to patients as appropriate.

Level 2:

- Supply of NRT to patient, and referral to Toki Rau.
- The general practice receives an incentive payment of $10 for each eligible service user who is referred to Toki Rau and subsequently enrols. The incentive payment is payable on confirmation of enrolment on Ara Whanui IT System. Practices that refer to Toki Rau will use the Careselect platform. Practices will have discussed the referral process with the patient and have their consent for the referral. Toki Rau will provide feedback to the Practice with regard to the referral outcome and if a quit attempt was made.

Level 3:

Supply of NRT to patient, referral to Toki Rau, and practice based stop smoking support.

General practices will be required to:

a) Provide the stop smoking service completely free of charge to patients
b) Meet MoH Tier One Service Specification for stop smoking services
c) Nominate a Stop Smoking champion as a first point of call within the general practice
d) Agree to use existing database for reporting purposes
e) Ensure staff (nurses, health care assistants, health coaches etc.) have been trained in stop smoking support, and commit to on-going training / professional development
f) Ensure quit attempts are validated through CO-monitor (a device to measure carbon monoxide ppm level, also known as a 'smokelyser'). The CO monitor is to be used as a quitting aid

Provide an incentive to hapū mama and wāhine Māori to complete a CO-monitor validated quit attempt.

Appendix 3 Northland Intersectoral Forum structure

See 2.5.12 Cross-sectoral collaboration including Health in All Policies, action 9.