NORTHLAND DISTRICT HEALTH BOARD

Te Poari Hauora Ā Rohe O Te Tai Tokerau

ANNUAL PLAN

2018/19

incorporating

STATEMENT OF PERFORMANCE EXPECTATIONS 2018/19

and

STATEMENT OF INTENT

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

15 MAY 2019

Mrs Sally Macauley QSM
Chair
Northland District Health Board
sallygmac@xtra.co.nz

Dear Sally

Northland District Health Board's 2018/19 Annual Plan

This letter is to advise you I have approved and signed Northland District Health Board's (DHB's) 2018/19 Annual Plan for one year.

I note your DHB has planned a deficit of $7.5 million for 2018/19 and reducing deficits in the out years.

I have been clear that I expected the total DHB sector financial position for 2018/19 to be an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important that DHBs are doing all they can locally to manage their business in a financially prudent way. Although I am approving your Annual Plan, I expect that you will continue to focus on opportunities for improving financial results in 2019/20 and beyond.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective health services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Dr Nick Chamberlain, Chief Executive, Northland District Health Board
nick.chamberlain@northlanddhb.org.nz

Contents

1 Strategic priorities

1.1 Strategic intentions and priorities

Vision and mission

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

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

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

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

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

In discussing local priorities with the Ministry of Health for 2018/19, the Ministry focused on the following areas. These align with national directions and the strategic themes identified by our Board. Actions in support of these local priorities are mentioned in other sections of the Annual Plan.

Strategic framework. Northland DHB will develop a strategic framework based in part on a health needs assessment. It will be high-level, cover all health services in Northland, and focus on population-level objectives, planning priorities and partnership principles.

Māori health review. A review of Māori health planning and service provision, both internal and external to the DHB, is currently underway. It includes community engagement with Iwi to confirm Māori health priorities. Māori health services across Northland will be reviewed to ensure they are fit-for-purpose and where necessary new models of service delivery will be designed collaboratively.

Collaboration Kaupapa. Northland DHB is part of a process that is heading towards a single primary care entity by 1 July 2019. A single intermediary and contracting relationship is being established across our two current PHOs, and this will be bolstered by locality-based advisory groups and a planning process that involves Whānau and community right from the start.

Neighbourhood Healthcare Homes. Jointly sponsored by the DHB and the two PHOs, so far ten practices are participating with good coverage across Northland. We will extend the model further and continue to ensure that equity is a key component.

Cross-agency work. We will continue to work with other agencies to address the needs of our population. We will maintain involvement in successful programmes such as: Te Ara Oranga, working with Police on methamphetamine harm reduction; the Kainga Ora Place Based Initiative, which involves Whangarei District Council and others; Rakau Rangatira, which provides psychology counselling services to Otangarei Work and Income clients.

Whangarei Site Master Plan. We currently have a number of business cases under consideration by the Capital Investment Committee. These include interim works required to address issues critical to our facilities and services until the new development is completed.

Northland DHB's full list of priorities for 2018/19 appears in Appendix C **Commitments**

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

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

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

> Among DHBs, Northland has one of the highest percentages of older people in our population (in 2017, 19.8% compared with 15.4% 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** (refer 2.1.21 Disability Support Services) also forms part of Northland DHB's disability strategic framework, with service improvements for 2017/18 focussing on accessibility, attitudes, health and wellbeing, and leadership.

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

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

1.2 Population performance

These actions in the plan are anticipated to deliver the most significant gains for each of these stages of the life course.

Life course group	Action	Location in plan
Pregnancy	1 Develop and establish a programme of Kaupapa Māori group session antenatal education across Northland, incorporating a train the trainer model of delivery in partnership with Māori NGO, health, social services and Māori midwives. ***EOA ACCESS***	2.9 Child health: Child wellbeing
Early years and childhood	2 Improve newborn enrolment in general practice: • implementation of NCHIP • establishment of the information hub – colocation of NIR with NCHIP • continue the checking of GP enrolment information for pregnant woman registering with birthing facility; work with LMC and PHO to mitigate issue of enrolment. ***EOA ACCESS***	2.9 Child health: Child wellbeing
Adolescence and young adulthood	1 Continue implementation of the new model of service delivery for youth school-based services in collaboration with PHO and Māori NGOs. ***EOA ACCESS***	2.12 Child health: School-based health services
Adulthood	2 Establish a new structure (mirroring components of the Canterbury Initiative) across the primary-secondary interface, which will have two components: • a recurring forum in which senior primary and secondary clinicians will systematically review and standardise pathways, and identify initiatives and opportunities to improve patient access and reduce acute demand • an action arm to facilitate and support the forum, and drive projects and initiatives that emerge from it; they will also support and participate in broader integration projects including the Acute Demand Alliance and the Health and Social Care Coordination Project. ***EOA ACCESS***	2.5 2.5 Primary care: Integration
Older people	3 Prioritise promotion of the falls and fracture prevention services in general practices/ primary care to continue to increase enrolments across Northland. Year 1 In-home baseline is 21 clients per month. ***ACCESS***	2.16 Healthy ageing

1.3 Message from the Chair and Chief Executive

Northland District Health Board will continue to improve the delivery of services during 2018/19 while living within our means. Northland DHB is committed to the Government's aim of delivering better public services within tight financial constraints, local strategic goals and the NZ Health Strategy.

The Board maintained a balanced financial position from 2003 till 2017/18 when we had a deficit budget for the first time. Now that our funding is again determined by an uncapped population formula, we are aiming to achieve break-even in three years.

Northland DHB has a continuing commitment to improving efficiency and investing upstream to reduce demand for and the cost of expensive hospital care. Significant savings are factored into the plan from our own initiatives, procurement and supply chain savings. We are also committed to strengthening our organisation's 'Collective Leadership' and continuous improvement capability to assist in managing the significant and sustained demand growth, while improving employee wellbeing. Our Innovation, Improvement and Excellence programme will support this commitment.

We continue to strive to improve performance on Health Measures. We meet or exceed health measures for advice to smokers for maternity services and Raising Healthy Kids. Faster cancer treatment is close to target, and while ED waiting times remain below target, we are implementing a number of new initiatives to improve patient flow including an Integrated Operations Centre and a "one-up bed policy. Advice to smokers in primary care is inching closer to its target after considerable efforts from our PHOs. Immunisations remain stubbornly below target, a consequence of the extraordinarily high decline rate in Northland rather than large numbers of missed children. We are again focusing on supporting practices and ensuring all of them are applying best practice recall etc. processes.

We continue to be challenged by health inequities for Māori. We are planning to invest more in Māori Health and have consulted with our communities and are now working with our Māori Health Providers to review their contracts and look at increased, improved and better value services delivering better health outcomes for Māori. We have 20% of our Population over 65 and it is rapidly ageing. There is also 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 the second fastest growing and the second-largest of the mid-sized DHBs. This perfect storm of demographic change is driving unprecedented growth in demand (5% in 2017/18) across all services.

Neighbourhood Healthcare Homes are one of our major Primary healthcare initiatives, which introduces new models of care that better integrate services across the health and social sector, and establishes multidisciplinary networks that support general practices. We are currently supporting ten practices to implement the new models from the first two tranches, and the third tranche is in the pipeline.

We are also expanding the Primary Options Programme to ensure the "options" to avoid admission are much broader and will also support earlier hospital discharge. The collaboration Kaupapa will result in a single PHO by 1 July 2019. This enhanced PHO will have shared governance and ownership between our PHOs/ General Practices, Māori health providers and Hapu and Iwi. Northland DHB will also attend meetings and have an Alliance agreement with the new PHO. It will oversee locality engagement and planning, is likely to have a commissioning role and will be accountable for performance and reducing inequities.

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

Northland DHB is working alongside our PHOs to complete a Health Needs Analysis and develop a Northland health strategy . It will be a high-level roadmap, cover all health services in Northland, focus on population-level objectives, planning priorities and partnership principles. Over time it will

enable medium term (3-5 year) and annual plans within Northland DHB to be aligned, and provide the opportunity for health sector organisations across Northland to align their plans.

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

Northland DHB works very closely with our intersectoral partners to help improve socioeconomic outcomes for Northlanders. We will continue our membership of the Northland Intersectoral Forum. Northland DHB is a key partner in Kainga Ora, the Social Wellbeing Governance Group which is working with children and youth in our most vulnerable kainga (homes) in Kaitaia, Kaikohe and Otangarei. The aim is to achieve better social outcomes for children and youth. The issues are proving to be complex, involving a range of networks (MSD / Oranga Tamariki, Police, Northland DHB, Corrections, housing, education among others) which necessitates a focus on kainga rather than individuals.

Northland DHB plans to undertake a number of works to ensure essential critical capacity is maintained in the medium term, including two new operating theatres, a new endoscopy suite, and a new cardiac catheterisation laboratory. Longer term, a new Whangarei Hospital is needed; the strategic business case for this has been approved and we are working through the Programme Business Case which examines options for where this is sited. We have been recently informed that this may be up to 15 years away, and we will be submitting a business case for funding of a significant new building as well as building remediation to address the critical capacity and compliance issues during this period. It will include an Acute Assessment Unit, Paediatrics, Special Care Baby Unit, Outpatient and Ward capacity.

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

1.5 Signature page

Hon. Dr David Clark
Minister of Health

Sally Macauley
Chairman
Northland District Health Board

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

Dr Nick Chamberlain
Chief Executive
Northland District Health Board

2 Delivering on priorities

Codes that appear beside actions denote the following:

EOA	Access	NRHP
equity outcome action	actions that strengthen access to publicly-funded health services	actions that support the delivery of the Northern Region Health Plan

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.1 Mental health: Population mental health	Outline actions to improve population mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental and addiction and physical health care, and coordinating mental health care with wider social services.	One team	MHA services will roll out the MoC for the sector over the next twelve months. Key priority areas are listed below.		
			1 Te Ara Oranga will continue in year 2 Intention is to increase the focus on tikanga based services.	Ongoing	
			Vulnerable Children and Youth		
			2 MHA child/ youth services will develop specific pathways of care and standardised treatment approaches for the top two presenting issues/ referral reasons to child/ youth MHA services: • ADHD and behavioural issues • anxiety and depression.		
			3 Enhance consumer feedback into MHA child/ youth services by establishing two part-time consumer advisory roles based in Whangarei and the Mid and Far North MHA teams.		
			3.1 Development of implementation plan for child/ youth MHA service teams.	Oct 2018	
			3.2 Identify key actions and milestones.	Dec 2019	
			3.3 Develop measures for ongoing monitoring and review.	Feb 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	**Milestone**	
			3.4 Confirm role descriptions, following the Werry Centre's 'participation' model.	Jun 2019	
			Māori and Pacifica		
			45 Culturally enhanced clinical practice: MHA services will take a workforce development approach to mental health services in partnership with the Northland DHB Māori Directorate. It is envisaged that this action will assist with reducing inequities for Māori accessing MHA services.		
			4.1 Development of a collaborative implementation plan (across services). ***EOA***	Oct 2018	
			4.2 Convene a clinical/ cultural steering group to provide oversight. ***EOA***	Oct 2018	
			4.3 Develop a framework and strategic action plan to deliver enhancement of cultural competency across the MHA workforce. ***EOA***	Jan 2019	
			4.4 Include completion of cultural training as part of staff KPIs. ***EOA***	Apr 2019	
			5 *Outcome measurement approach across all services*		
			5.1 Introduce team/ service data forums across the region to utilise dashboard data. ***NRHP***	Oct 2018	
			5.2 Develop implementation plan for services.	Oct 2018	
			5.3 Identify key actions and milestones.	Dec 2019	
			5.4 Develop measures for ongoing monitoring and review.	Feb 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			5.5 Create NGO data forum to review/ refine existing Results Based Accountability reporting measures.	Oct 2018	
			6 *Improved integration and collaboration between other health and social services – primary health initiative*		
			6.1 Establish a primary mental health pilot project, focused on increasing community access to brief interventions in primary health settings. ***ACCESS***	Oct 2018	
			6.2 Explore opportunities to extend the ProCare Primary Mental Health model (currently based in Auckland) to Northland. ***ACCESS***	Ongoing	
			6.3 Work to secure training for primary practitioners (including sourcing additional funding). ***ACCESS***	Jan 2019	
			7 Supporting Parents, Healthy Children (SPHC)		
			7.1 Refresh the SPHC plan to reflect stage two implementation planning across the MHA sector (for NGOs, PHOs, DHB) in Northland.	Oct 2018	
			7.1 Establish a baseline of SPHC service initiatives across the MHA sector (for NGOs, PHOs, DHB).	Jan 2019	
			7.3 Explore and confirm a mechanism for ongoing reporting.	Apr 2019	
			8 Housing First implementation in Northland.		
			8.1 Support the establishment of a Housing First Model across MHA services. ***ACCESS***	Oct 2018	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			8.2 Participate in the Ministry of Social Development Housing First pilot based in Whangarei. ***ACCESS***	Oct 2018	
			8.3 Engage with key stakeholders. ***ACCESS***	Jan 2019	
			8.4 Participate in the development of a collaborative implementation plan (across services). ***ACCESS***	Jan 2019	
			9 To make MHA services more accessible, relocate them to an integrated community hub facility in the Whangarei city area. MHA services want to locate alongside other community agencies and are currently engaged in discussions with agencies to source an appropriate site.	Jan 2019	
			Convene a working group to lead this work.	Oct 2018	
	Outline how the DHB will ensure your staff and members of your community will be encouraged to participate in the Government Inquiry into Mental Health and Addiction.		10 MHA services will complete submissions regarding the Inquiry into Mental Health and Addiction Services	May 2018	
			11 MHA services plan will host the Inquiry into Mental Health and Addiction Services (based in Whangarei, Kaikohe and Kaitaia).	June 2018	
			12 MHA services will coordinate attendance by key groups regionally including PHO, NGOs, Iwi groups, and the broader community.	June 2018	
			13 Await recommendations from the Inquiry.	Oct 2018	
			14 Review the recommendations (and collate priorities for integration for the Northland region).	Jan 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.2 Mental health: Mental health and addictions improvement activities	Outline your commitment to the HQSC mental health and addictions improvement activities with a focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions.	One team	1 Zero seclusion strategy:		
			1.1 Complete the six core strategies for reducing seclusion planning tool.	Oct 2018	
			1.2 Develop a co-design strategy with key stakeholders.	Jan 2019	
			1.3 Facilitate a co-design meeting with clients and Whānau.	Oct 2018	
			1.4 Design and implement staff development workshops.	Oct 2018	
			1.5 Develop relevant staff KPIs.	Apr 2019	
			2 Transitions from Emergency Department – to reduce the time adult MH consumers spend in the ED setting:		PP7
			2.1 Develop a memorandum of understanding between MHA and ED services.	Oct 2018	
			2.2 Outline roles, responsibilities and pathways between MHA and ED services.	Dec 2018	
			Identify frequent presenters at ED who present with MH comorbidities.	Jan 2019	
			2.3 Map a series of client journeys.	Mar 2019	
			2.4 Facilitate a MH First Aid course with ED staff.	Jan 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.3 Mental health: Addictions	For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance.	Value and high performance	1 Establish an integrated MHA DHB/ NGO Addictions Forum with membership across services. 1.1 Share PP8 wait time data with providers as part of Addictions Forum. ***ACCESS*** 1.2 Explore alternative options to engage clients in addiction treatment pathways, including use of regional addiction treatment navigation roles. ***ACCESS*** 1.3 Consider the introduction of clinics targeting key referral groups to better manage demand for services (such as Corrections referrals). ***ACCESS*** 1.4 Review triage processes for addiction services. ***ACCESS***	Development of implementation plan for MHA service teams by Oct 2018. Identify key actions and milestones by Jan 2019. Develop measures for ongoing monitoring and review by Apr 2019.	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.4 Primary care: Access	Describe actions that will ensure at least 95% of eligible children up to the age of 14 years have zero fee access to: • general practice during regular hours within 30 minutes travel time (including exemption from the standard $5 charge on prescription medicine items) • after-hours care within 60 minutes travel time. This includes general practice services and prescriptions. DHBs will also ensure information in relation to practices/ clinics providing zero fee daytime access and zero fee urgent after-hours arrangements is publicly available on their websites.	Closer to home	1 Revise current under 13s contract with general practices to include additional PSAPP negotiated funding and extend contract to include under 14s from 01 Dec 2018. ***ACCESS*** 2 Review current contracts with general practices to include additional PSAPP negotiated funding to reduce fees to CSC card holders. ***ACCESS*** 3 Develop under 14 enrolment key messages to mitigate change of in-hours casual payments by 01 Dec. ***ACCESS*** 4 Work with Northlands two PHOs, community pharmacies, Māori / Iwi providers and local after hours services to ensure consistency across the district to reduce all applicable (under 14s and Community Services Card holders) fees and key messages. ***ACCESS*** 5 Communication of the expansion of the eligibility criteria via DHB Facebook page. DHB and PHO websites updated to reflect changes accordingly. ***ACCESS***	Accurate website information to reflect changes Communication activities undertaken to inform population about changes to eligibility criteria Contracts varied and signed with providers	% of eligible children up to the age of 14 years have zero fee access to: • general practice during regular hours within 30 minutes travel time • exemption from the standard $5 charge on prescription medicine items • after-hours care within 60 minutes travel time. % of eligible children up to the age of 14 years have zero fee access to:

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	**Milestone**	
			6 Acute demand management:		
			6.1 Employ a senior Clinical Director to lead a programme of work to establish terms of reference and scope a direction of travel to inform system wide flow of acute demand in Northland .	Q1	
			6.2 Establish the Northland Acute Integrated Demand Service; a system wide single point of contact with dedicated resources to coordinate service delivery that meet patients presenting acute demand – including identifying alternative treatment locations to a secondary care setting. This will replace our current Primary Options Programme with a significant increase in scope, flexibility and volumes.	Q2	
			6.3 Build upon and mature the Acute Demand Alliance by establishing a formal Northland Acute Demand initiative.	Q3	
2.5 Primary care: Integration	DHBs are expected to continue to work with their district alliances on integration including (but not limited to): • strengthening their alliance • broadening the membership of their alliance • developing services, based on robust analytics, that	Closer to home	1 Northland DHB will continue to play a key role in the Collaboration Kaupapa. The Establishment Board, in which we participate in an ex-officio role, has worked with the Trust to develop a Trust Deed. The programme management structure has been reviewed and a new Steering Group is to be established to lead the project workstreams. ***EOA ACCESS***	Establishment of the new entity, localities and new planning and funding mechanisms will be complete by June 2019.	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
	reconfigure current services. In addition: • please identify actions you are undertaking in the 2018/19 year to assist in the utilisation of other workforces in primary health care settings.		2 Establish a new structure (mirroring components of the Canterbury Initiative) across the primary-secondary interface, which will have two components: • a recurring forum in which senior primary and secondary clinicians will systematically review and standardise pathways, and identify initiatives and opportunities to improve patient access and reduce acute demand • an action arm to facilitate and support the forum, and drive projects and initiatives that emerge from it; they will also support and participate in broader integration projects including the Acute Demand Alliance and the Health and Social Care Coordination Project. ***EOA ACCESS***	During 2018/19.	Pathway to be identified and appropriate measures developed once the forum is established.
			3 Roll out tranche 3 of the Neighbourhood Healthcare Homes programme, bringing the total number of patients enrolled with an NHH practice to 117,000. ***EOA ACCESS***	30 June 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			4 Progress the Health and Social Care Coordination Programme, strengthening opportunities for integration across primary, community (government, NGO and voluntary sector) and secondary care, with the following goals achieved by: 4a *Multidisciplinary Team Meetings (Standards).* Embed two agreed standards (virtual and face-to-face) for primary care-led multidisciplinary team meetings. 4b *Locality-based networks.* Primary and community health and social care networks established across the Northland region in defined geographic localities, working together with primary care to optimise utilisation and coordination of available community health and social care resources for the benefit of patients. 4c *Northland Community Hub (centralised triage process).* A central point of referral, triage and scheduling of in scope community nursing and allied health services established, to be called Northland Community Hub. 4d *Workforce capacity and capability building – the Calderdale Framework.* Introduction of the Calderdale Framework (task delegation and skills sharing) and enable the development of a contractual agreement, change management and governance structures to guide the application of the Calderdale Framework in Northland, particularly to provide more community nursing and allied health service. ***EOA ACCESS***	30 June 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			5 Deliver a new Northland health strategy that describes Northland DHB's future vision of healthcare. It will address, among other things, innovative and integrated workforces across primary care. ***EOA*** ***ACCESS***	Early 2019	
			6 Northland Community Pharmacy Services Development Group, will ring-fence a pool of funding to develop the community pharmacy workforce by funding training in Medicines Therapy Assessments, Medicines Use Reviews, Clinical Diplomas and where appropriate fund training for Pharmacist Prescribers	Q1 2018/19	
			7 Subject to additional funding negotiated through the national pharmacy contract process, identify and establish projects which promote the use of pharmacists as medicines experts within the health system. Understand how pharmacists can act as an interface between secondary and primary care, and maximise health outcomes. For example, implement an integrated Medicines Use Reviews and Medicines Therapy Assessments services. ***ACCESS***	Q3 2018/19	
			8 Work with primary care to establish new models of care, maximising clinicians' ability to work at the top of scope through introducing roles such as Healthcare Assistants. As a minimum, increase the number of general practices that utilise a healthcare assistant workforce from 6 to 10. ***ACCESS***	30 June 2019	
	Identify actions to demonstrate how you will work proactively with your PHOs and other providers to improve newborn enrolment with general practice in 2018/19.		See 2.9 Child health: Child wellbeing, action 2.		

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.6 Primary care: System Level Measures	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	Value and high performance	Appendix B: System Level Measures Improvement Plan		
2.7 Primary care: CVD and diabetes risk assessment	Commit to maintaining a rate of 90% in undertaking CVD and Diabetes Risk Assessments for their eligible population. Those DHBs whose current performance is below 90% are expected to work closely with their alliance partners to achieve 90%. These DHBs must describe specific actions their alliance will take to reach this target. These actions could be part of the actions committed to in the System Level Measures Improvement Plan (specifically in achieving the Acute Bed Days or Amenable Mortality SLMs), in which case this should be cross-referenced, if that is appropriate. If specific risk assessment activity is not part of the SLM Improvement Plan, actions to improve the level of risk assessments provided must be included in this section along with two	One team	1 Ensure that CVD and Diabetes Risk Assessment is a standing item on the Northland Diabetes Strategic Advisory Group to provider oversight and governance on achievement of the 90% target including proactively identifying strategies to achieve equity.	Q1	
			2 Our priority population is Māori males aged 35 to 44 years who have had a CVDRA in the last 5 years. Described Improvement plan and strategy in place.	Q2: strategy identified and in place.	
			3 Diabetes priority 1: Increase the number of Māori males aged 35 and above who have been screened for diabetes in the last 5 years by implementing an incentivised primary care afterhours screening project across Tai Tokerau.	Q4	
			4 Diabetes priority 2: People with diabetes should receive personalised advice on nutrition and physical activity together with smoking cessation advice and support if needed. Maximise access to Green Prescriptions services for patients with diabetes to receive physical and nutritional advice.	Q3	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
	quarterly milestones. In addition each DHB should identify three priority areas they will be undertaking for quality improvement in diabetes care and services with key actions and milestones. These areas may be informed by their self-assessment against the Quality Standards for Diabetes Care 2014.		5 Diabetes priority 3: The Ministry of Health, in partnership with the Heart Foundation, has published guidance documents about changes to the criteria for Cardiovascular Disease Risk Assessments and Management and to the Diabetes Annual Review advanced form. The changes relate to changes to eligible populations. Along with these changes Enigma Predict updated and released the Diabetes Annual Review advanced form to include some new measures that have not been formerly socialised. Given that the CVD Risk Assessment and the Diabetes Annual Review occur on the same Advanced Form there is an opportunity to ensure both these areas of change are launched in a deliberate way:	
			2a Completion of Communication Plan	Q1	
			2b Timeline for IT support tool development	Q2	
			2c Education programme defined.	Q1	
			2d One Point Lessons development	Q1	
			2e Checklist for future implementations established	Q2	
			2f Socialise methodology to general practice teams and PHO staff as a way of working in the future with projects/programme launching work into general practice.	Q2	
			2g Reference documents available to general practice and Manaia PHO staff.	Q2	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.8 Primary care: Pharmacy Action Plan	Continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community. Continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (e.g., primary health care) to develop integrated local services that make the best use of the pharmacist workforce.	One team	1 Northland DHB commits to delivering on the Pharmacy Action Plan and participating in the implementation of the new national pharmacy contracting arrangements to replace the Community Pharmacy Services Agreement expiring on 30 September 2018. Northland DHB will continue to invest in developing relationships with the Northland pharmacy sector. Northland DHB recognises that community pharmacists have a pivotal role to play in a safe health system. Community pharmacy occupies a unique space as crucial touch point between all parts of the Northland health system with contact with all prescribers. From 1 October 2018 the new agreement will enable the development of patient-centric services and local DHB commissioning for integrated pharmacist services to meet population needs from within a national contracting framework. The contract and funding arrangements will take into account various features of the PHO Services Agreement, and encourage integration across pharmacy, primary care and aged residential care. ***ACCESS***	1 Oct 2018	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			Service change – potential change in model of service delivery using framework of new contract: The Northland Community Pharmacy Services Development Group will identify and recommend opportunities for Northland DHB to develop services that use the skills of pharmacists as medicines experts, promote integration and improve patient outcomes. Northland DHB will work towards different contracting arrangements for the provision of community pharmacist services by working with consumers and other stakeholders within the framework of the new contract to develop and agree some local service options for local priorities.	Services designed and commissioned will be required to consider how they will contribute to the reduction of health inequities in our priority populations: • Māori • older people • those living in low socioeconomic decile.	
2.9 Primary care: Support to quit smoking	Please identify activities that continue to support delivery of smoking ABC in primary care	One Team	PHOs will continue to adapt methods and strategies to accommodate the needs of our varied general practices, so that we continue to see improvements in quarterly reporting and the delivery of ABC.	Ongoing	Number of completed ABC programmes. Number of successful follow ups. Number of successful follow ups identified as Māori and Pacific. 2000 successful quits each year.
			Primary care increase ABC capacity in clinics through use of primary health care assistants	Ongoing	
			Continue to work with our PHOs, GPs and stop smoking services, targeting high needs populations including Māori, PI and high deprivation populations.	Reduction in gap between high need smokers and others	
			Referral pathways are developed between primary care and community-based Stop Smoking Services	Ongoing	
			Tobacco Control Service Level Alliance Team monitors and tracks primary care smoking cessation performance	Quarterly	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.10 Child health: Child wellbeing	Please identify the most important focus areas to improve child wellbeing and that realises a measurable improvement in equity for your DHB. Identify key actions that demonstrate how the DHB is building its understanding of population needs, including those of high-needs populations, and making connections with and between local service providers of maternal health, child health and youth focused services.	Value and high performance	1 Develop and establish a programme of Kaupapa Māori group session antenatal education across Northland, incorporating a train the trainer model of delivery in partnership with Māori NGO, health, social services and Māori midwives. ***EOA ACCESS NRHP***	By June 2019	Scheduled programme of hapu wananga delivered in Kaitaia, Rawene, Kaikohe, Kawakawa, Whangarei, Dargaville. % of pregnant Māori women attending the programme. Survey of attendees pre-post skills knowledge and attitudes undertaken at each wananga.
			2 Improve newborn enrolment in general practice: • implementation of NCHIP • establishment of the information hub – colocation of NIR with NCHIP • continue the checking of GP enrolment information for pregnant woman registering with birthing facility; work with LMC and PHO to mitigate issue of enrolment. ***EOA ACCESS NRHP***	By June 2019 Report on activities in the Annual Plan	55% of newborns enrolled in general practice by 6 weeks of age. 85% of newborns enrolled in general practice by 3 months of age. Decrease # of woman with unknown or incorrect GP at time of birth.
			3 Continue to develop the integrated MoC with emphasis on care coordination for: • children in quintiles 4-5 • tamariki Māori with long-term conditions or ASH-specific illness. ***EOA ACCESS NRHP***	By June 2019	# of children (by ethnicity) receiving care coordination using the new model of service delivery.
			4 Establish the care coordination model for children with high ED utilisation and readmissions to paediatric inpatient services, focussing initially on children with acute respiratory (asthma and bronchiectasis) but extending to include other long term conditions where deprivation impacts on health outcomes. ***EOA ACCESS NRHP***	By June 2019	Tracking ED utilisation and admission for prioritised children over time – decrease utilisation. Decrease in overall # of readmissions for asthma and bronchiectasis in a 12 month period.
2.11 Child health: Maternal mental	Commit to have completed a stock-take by the end of quarter two, of community-based	Closer to home	1 Complete a stocktake of community based maternal mental health services (both antenatal and postpartum).	Jan 2019	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
health services	maternal mental health services currently funded by your DHB, both antenatal and postpartum. Please include funding provided to PHOs specifically to address primary mental health needs for pregnant women and women and men following the birth of their baby. Commit to identify, and report in quarter four on the number of women accessing primary maternal mental health services both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service.		2 Identify all funding sources for maternal mental health services (including PHO funding).	January 2019	
			3 Establish a reporting mechanism to identify the number of women accessing primary maternal mental health services through: • PHO contracts • Mental health services.	Develop measures for ongoing monitoring and review by Apr 2019	
2.12 Child health: Supporting health in schools	Identify actions currently under way to support health in schools by the end of quarter two, an example can be found on the FAQ sheet on the NSFL. (in addition to School-Based Health Services – see guidance below).	Closer to home	1 Continue to develop the integrated MoC with emphasis on care coordination for children in quintiles 4-5; tamariki Māori with long-term conditions or ASH-specific illness. ***EOA ACCESS NRHP*** 2 Reorient the PHN model of care toward improved access for children aged 5 to 12 to primary care and child health services; especially for children with complex social and/or long term conditions. ***EOA ACCESS*** 3 Increase capacity of current Kaiawhina service toward a directorate-wide approach to service delivery. ***EOA ACCESS***	By June 2019	# of children receiving care coordination for ASH and long term conditions by ethnicity. Reduction in readmissions for same DRG code. Reduction in number of children accessing ED after hours for primary care related conditions.
2.13 Child health: School-based health services	Commit to have completed a stocktake of health services in public secondary schools in the DHB catchment (MoH to provide list of schools) by the end of quarter 2.	Value and high performance	1 Continue implementation of the new model of service delivery for youth school-based services in collaboration with PHO and Māori NGOs. ***EOA ACCESS***		All secondary schools have access to onsite youth health service. # of students accessing service. # of Māori students and Q5 students accessing SBHS.

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
	Commit to have developed an implementation plan including timeframes for how SBHS would be expanded to all public secondary schools in the DHB catchment (MoH to provide template) by the end of Q4. Note that the implementation plan should include an equity focus.		2 Stocktake of health services in public secondary schools in Northland DHB catchment. 3 implementation plan developed, using an equity focus. Template to be provided by MoH.	June 2019 Q4: Implementation plan developed as per MoH template.	
2.14 Child health: Immunisation	Work as one team across all immunisation providers within your region, and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood. This includes delivery of the primary series of vaccines under one year of age, and completion of immunisations due at two and five years of age, with a particular focus on increasing immunisation rates for Māori infants.	One team	1 Establish administration capacity in PHOs to support GP in pre-call and re-call activities. ***EOA Access*** 2 Examine the current messaging, and work with marketing specialist to develop a communications strategy targeting all Whānau with young families, commencing in pregnancy. ***EOA Access NRHP*** 3 Expand options for after-hour access to immunisation, particularly in rural Q5 areas. ***EOA Access NRHP*** 4 Working in collaboration with primary care, strengthen pre-call and re-call processes and opportunistic engagement with Māori Whānau through expanding the providers who can offer immunisation (that is, Tamariki Ora / Māori NGOs). ***EOA Access NRHP*** 5 Working with the Māori coordinator of Hapu Wananga to present immunisation information that is meaningful and relevant to Māori Whānau. ***EOA Access NRHP***	Administration support provided June 2019 Q4 a marketing plan developed using co design June 2019 Q4 options identified December 2018 Q2 Administration support provided December 2018 Q2 key messages agreed	Increased in timely immunisation in prioritised practices. # of children vaccinated on time for each milestone. Audit of pre-call and re-call in targeted GPs. # of after-hours venues offering immunisation. # of immunisation given in after hour clinics. # of Māori children vaccinated on time for each milestone.
	Please provide three specific actions that will increase Māori infant immunisation coverage levels and sustain high levels during 2018/19. These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved.	Value and high performance			
2.15 Child health: Responding to	Please identify activities that continue to respond to children identified as obese at their B4		Activities currently worked on: 1 Coordinator continues to monitor the referral data checking database weekly	 Q1-Q4 – ongoing throughout the year	Raising Healthy Kids Health Target

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
childhood obesity	school check.		2 Coordination service is entering the data into the B4SC database for some providers therefore is able to check the growth information to ensure it has been captured appropriately.	Q1-Q4 – ongoing throughout the year	
			3 Following on from recent training of new staff in B4SC providers, undertake training of 30 PHNs and 7 staff in Māori health providers (and confirm further staff for training during Q2).	Q1	
			4 Continue Manaia PHO dietician work in supporting general practice teams to be able to assess children, visiting Māori health providers and being involved in the above training.	Q1 for training, ongoing for the rest	
			5 Referrals are sent to the Northland DHB Kaiāwhina support service for childhood obesity. Referred children and their Whānau will be contacted and offered to participate in the He Pihinga Ora Programme. If accepted the Whānau will be supported by a Kaiāwhina to discuss issues that may be contributing to the child's weight, to develop an action plan and then with the ongoing implementation of the plan. The programme will also continue to hold quarterly Whānau Pool Days where healthy eating, exercise and lifestyles are discussed.	Q1-Q4 – ongoing throughout the year	
			Note: A major well child provider has recently ceased their contract for providing B4SC in Northland which has increased our current workload. Once we have caught up, more work will be done with B4SC tamariki in general practices.		

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.16 Access to elective services	Please provide three specific actions that will support your delivery of the agreed number of Elective discharges, in a way that meets timeliness and prioritisation requirements and improves equity of access to services. At least one action to improve equity of access to Elective Services should be included. These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved.	Value and high performance	1 Reform of operating theatre schedule at Whangarei Hospital to provide dedicated acute orthopaedic operating sessions and commissioning of additional operating capacity including evening and weekend elective operating sessions. ***ACCESS***	Oct 2018	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators
			2 Explore the feasibility of undertaking low risk primary joint replacement surgery at Kaitaia Hospital and, subject to feasibility being confirmed, commencing this surgery. ***ACCESS***	Oct 2018	
			3 Establish a Māori Senior House Officer role in General Surgery to undertake research activity in the field of Māori access to surgical services and contributing to the provision of outreach surgical services at Kaitaia Hospital. ***EOA ACCESS***	Dec 2018	
2.17 Cancer services	Implement improvements in accordance with national strategies and demonstrate initiatives that support the areas outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives. DHBs will describe actions to: • ensure equity of access to timely diagnosis and treatment for all patients • implement the prostate cancer decision support tool to improve the referral pathway across primary and	Value and high performance	*Ensure equity of access to timely diagnosis and treatment for all patients.*		PP30: Faster cancer treatment, Monitor the Quarterly report against ensure improvements can be made to meet acceptable targets. Review/screen referrals – Māori/PI are prioritised as complex. Northland DHB reporting captures all new and current patients. Stocktake of existing resources and gap analysis. Analysis of the patients that did not meet the FCT targets.
			1 Use regional and local performance data and recommendations to streamline tumour stream pathways, particularly where inequity exists. ***EOA ACCESS NRHP***	Mar 2019	
			2 Prospective identification, monitoring and intervention throughout the pathway by the CNS Māori/ PI Navigator. ***EOA ACCESS NRHP***	Sep 2018	
			3 Tumour Stream CNS's network with iwi providers and psychological support throughout Northland, identifying high risk Māori/PI DNA and barriers (health statistics, institutional racism and complex referrals etc.). ***EOA ACCESS***	Mar 2019	
			4 Targeted development of patient and staff resources including education. ***NRHP***	Ongoing	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
	secondary services • provide support to people following their cancer treatment (survivorship).		5 Continued regional collaboration (formal and informal) and reporting to ensure cross-DHB pathways are timely and efficient, including: • Regional Faster Cancer Treatment (FCT) Group • Regional Oncology Operations Group • Regional Cancer Steering Group • Regular discussions with Cancer Society. ***NRHP***	Ongoing	
			Implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services.		
			6 Develop health pathways for primary care referrals to secondary care, in consultation with the urology service and GP Liaison. ***Access NRHP***	Undertake a comprehensive review of the current prostate pathway and identify areas for service improvement.	
			7 Regional collaboration to ensure equity of access to urology surgical services for patients with prostate cancer referred to the regional service. ***EOA Access NRHP***	Once an agreed regional pathway is identified it will be implemented.	
			8 Development of a prostate tumour stream pathway to be revised. ***NRHP***	CNS Urology do 1:1 clinics with patient & Whānau to discuss treatment options/ pathway & preparation for 1st treatment(Radiation, Surgery or Surveillance).	

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			9 CNS Urology to attend a Australian-NZ workshop to standardise nurse-led prostate cancer follow-up clinics.	Attend Radiation Oncology Clinics for Prostate Ca linking with ADHB for streamline process for patients /clinicians October 2018.	
			10 Implementation of the Pelvic Floor and Penile Rehab for Radical Prostatectomy patients. ***NRHP***	Sep 2018.	
			11 Participate on the National Genital Urology Steering Group.	Due to commence July/Aug 2018.	
			Provide support to people following their cancer treatment (survivorship).		
			12 Work with cancer related services to develop and/or enhance survivorship care plans within the services. ***NRHP***	Feb 2019.	Quarterly meeting with cancer-related services (Cancer Society, Hospice, GPs).
2.18 Healthy ageing	Deliver on actions identified in the Healthy Ageing Strategy 2016, involving older people in service design, co-development and review, and other decision-making processes , including: • working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in your integrated falls and fracture prevention services as reflected in the associated "Live Stronger for Longer" Outcome Framework and *Healthy Ageing Strategy:* • contributing to DHB and Ministry led development of Future Models of Care for home and community support	Closer to home	1 Retain Northland's integrated Falls and Fragility Fracture Prevention Clinical Governance Group, increasing to four consumer representatives/ community champions.	Q1	
			2 Work with national, regional and local ACC representatives to ensure Northland DHB's ongoing communication plan remains strategically focused as ACC continues to socialise and progress the National Live Stronger for Longer Campaign.	Q1-4	Ongoing process.
			3 Prioritise promotion of the falls and fracture prevention services in general practices/ primary care to continue to increase enrolments across Northland. Year 1 In-home baseline is 21 clients per month. ***ACCESS***	Q1	In-home annual target 252 clients. Uptake by ethnicity

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
	services. In addition, please outline current activity to identify drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations).		4 Northland DHB will review older people who have been assessed using an InterRAI CA which has flagged an urgency score >4, and who have not subsequently received a full InterRAI HC assessment to determine whether a comprehensive InterRAI assessment was necessary to inform NASC about the client's needs. Contributing factors will be identified. ***NRHP***	Q1-4	Conversion rate of CA to HC assessment,

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			5 Identify and respond to the drivers of acute demand. 5a Reduce ED presentations from residential care for those aged over 75 years. • continue to facilitate Northland DHB/ARC Aged Care Collaborative • monitor ED presentations and follow up ARC providers with increases in presentation rate • provide dedicated RN Practice Development support in ARC facilities • provide ARC RN access to DHB's LEARN e-learning courses • implement clinical pathways for common conditions in ARC • increase uptake of ACP. 5b Reduce ED presentations for falls and fragility fractures occurring in the community (PP23). for those over 65 years (50 years where benefit can be derived). *(See 3 above.)* 5c Reduce rate of admissions/LOS for those over 75 years • implement GNS/ Geriatrician-led ACE programme in ED, including comprehensive geriatric assessment and care planning at the "front door". 5d Earlier dementia diagnosis and support in primary and community care. • complete scheduled GP/ PHCT cognitive impairment/ dementia pathway education and training across Northland • complete a 6 month 'Proof-of Concept' programme of work to test the Mycare online community for self-directed support in the home, reducing carer burden increase referrals and equity of access for Māori PWD/ Whānau to Alzheimers.Northland community support services.	Q1-4	% total ED presentations. >80 years re-admission rates at 7 days. % acute admission rates from ED. #, % ARC admits to ED/1000 ARC bed days. Decrease in carer stress (InterRai). Referrals to Alzheimers Northland for Māori people with dementia will increase from 17%of total active clients (current baseline) to 25% by the end of Q4.

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.19 Shorter stays in Emergency Departments	Please identify activities that continue to improve patient flows through hospital.		1 ED In-Flow Reduce unnecessary Aged Residential Care admissions Gerontology GNS placement in ED	 Q1-4 Q4	*Process measures:* Percent % ARC ED admissions Reduce LOS in ED for those >80 years Reduce fragility fractures for those over 65 years (PP23)
			2 ED Through Flow Direct admissions from ED Pathway to medical services	Q2-3	*Outcome measure:* ED LOS reduction for medicine
			3 Whole of Organisation Operational Hub Total flow coordination(establish an integrated operations Centre)/daily planning huddles	Q4	Reduction in ED LOS for all patients specialties Reduce code reds
2.20 Disability support services	Commit to develop e-learning (or other) training for front line staff and clinicians by the end of quarter 2 2018/19 that provides advice and information on what might be important to consider when interacting with a person with a disability. (Some DHBs have developed tools which could be shared, contact DSS). Commit to report on what % of staff have completed the training by the end of quarter 4, 2018/19.	One team	1 A whole-of-sector/ consumer Disability Support Services Reference Group will continue to actively support the direction, opportunities for improvement and monitoring achievement of the agreed key actions for 2018/19, reporting to Northland DHB's CPHAC/DiSAC Committee.		Identify appropriate measures.
			2 Complete a revision of Northland DHB's mandatory Disability e-learning course adopting a two pronged approach that includes successfully completing the e-learning training, and face to face mentoring for yielding culture change and reflective practice.	Q2	Disability Responsiveness e-learning course completed Q2.

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
			3a Increase the annual percentage of e-learning completion rates for new and existing frontline staff and clinicians. 3b 2017 baseline for new starters completion rate: 62%. 3c 2017 baseline for existing staff/current headcount completion rate: 52%. 3d Denominator for frontline/ clinician headcount TBC.	Q4	New starters 80% Existing staff 80%.
			4 Continue to promote the Health Passport as a consumer-led communication tool for those with disabilities or impairment.	Q1-2	Number of service contacts.
			5 Develop easy-to-read/ storybook versions of patient information/ pamphlets for prioritised clinical procedures impacting those with disabilities and their carers.	Q3-4	Two easy to read tools completed.

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.21 Improving quality	Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to: - work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes) - improve patient experience as measured by your DHB's lowest-scoring question in the Health Quality & Safety Commission's national inpatient experience surveys.	Value and high performance	1Aim to improve patient experience with a focus on our lowest scoring question from the National Patient Experience Survey. This includes: • Provide good quality written patient information through the establishment of a standardised document control process that incorporates consumer review and co-design. • Develop and test a co-designed transfer of care (discharge summary) document to simplify and more effectively communicate information relating to medication use and side effects. • Provide training for staff to support effective engagement and relationship building with Māori patients and Whānau, and communication training (such as a guide to serious illness conversations, and advanced care planning courses).	March 2019	Identify appropriate measure/s Increase in overall positive response rate by 15%. *Asthma measures, including an equity focus, are incorporated within Appendix B: System Level Measures Improvement Plan under Ambulatory Sensitive Hospitalisations.*
2.22 Climate change	Commit to individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme). Commit to undertake a stocktake to be reported in quarter 2 to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change.	Value and high performance	1 *Reporting and monitoring.* Calculate carbon footprint for FY2017/18 (done yearly since 2016 and third party verified by Enviromark). 2 *Execution of measures.* Sustainability development manager to continue execution of the 2016 sustainability action plan, with the goal to reduce emissions by 15% in 2025 compared to 2016. Actions in the key areas energy, transport, waste, buildings, procurement and success drivers of commitment, communication, change management, collaboration, certification. The sustainability action plan and carbon footprint publications are publicly available at: https://www.northlanddhb.org.nz/about-us/sustainability/	Annual 2017/18 and 2018/19 carbon footprint publication on DHB website, including highlights of achievements.	Greenhouse Gas emission reduction of 5% in 2019 compared to 2016 (leading up to 15% in 2025).

Government planning priority	Focus expected from DHB	NZHS theme	DHB key actions to deliver improved performance		Measure
			Activity	Milestone	
2.23 Waste disposal	Provide actions to raise awareness and actively promote the use of your DHB's pharmaceutical waste collection and disposal arrangements. Commit to undertake a stocktake to be reported in quarter 2 of 2018/19 to identify activity/actions to support the environmental disposal of hospital and community (e.g. pharmacy) waste products (including cytotoxic waste).	Value and high performance	1 *Stocktake:* undertake a stocktake to identify activity/actions to support the environmental disposal of hospital and community (e.g. pharmacy) waste products (including cytotoxic waste). *2 Communication:* Campaign to reduce inappropriate disposal of pharmaceutical waste in the community and raise awareness of return options at pharmacies. 3 *Training:* Develop waste training for DHB staff for proper segregation and disposal methods of hazardous and recyclable waste of the hospital. 4 *Infrastructure:* Introduce more recycling bins and pick-up locations at the DHB. 5 *Reporting and monitoring:* Set up an integral monitoring system for waste disposal.	Online presence at DHB and Councils websites. Flyers and posters distributed to patients and pharmacies. Waste training implemented. 50+ more recycling bins. Waste monitoring.	Higher collected volumes of pharmaceutical waste. Reduction in hazardous waste volumes. Increased recycling volumes.
2.24 Fiscal responsibility	Commit to deliver best value for money by managing your finances in line with the Minister's expectations. Local improvement activities to respond to Government intentions (DHBs required to include actions in this sections will be advised)	Value and high performance			

<table>
<tr><th>Government planning priority</th><th>Focus expected from DHB</th><th>NZHS theme</th><th>DHB key actions to deliver improved performance</th></tr>
<tr><td>2.25 Delivery of Regional Service Plan</td><td>Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan.

In particular, for Elective Services, identify local actions to support planned Elective activity in the regional service plan across, Workforce, Clinical Leadership, Quality and Pathways. There is a strong focus on regional collaboration in 2018/19 for Orthopaedics, Ophthalmology, Vascular and Breast Reconstruction.</td><td>One team</td><td>The code NRHP has been inserted after actions throughout section 2 that link with or contribute to the delivery of the Northern Region Health Plan. The sections and action numbers concerned are:
<table>
<tr><th>Section</th><th>Actions</th></tr>
<tr><td>2.1 Mental health: Population mental health</td><td>6a</td></tr>
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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

Northland DHB continues to play a key role in the **Collaboration Kaupapa**. The Establishment Board, in which Northland DHB participates in an ex-officio role, has developed a draft Trust Deed with the Trust expected to be established in June. The programme management structure has been reviewed and a new Steering Group is to be formed to lead the project workstreams. Establishment of the new entity, localities and new planning and funding mechanisms will be complete by June 2019.

Northland DHB is initiating an independent review of **Whangaroa Health Services**. The review will be completed by mid-August and recommendations implemented by 01 October.

In consultation with Auckland DHB a **cardiac catheter laboratory** will be developed in Northland to bring another service closer to home.

Potential change in model of service delivery using framework of new contract. The Northland Community Pharmacy Services Development Group will identify and recommend opportunities for Northland DHB to develop services that use the skills of pharmacist as medicines experts, promote integration and improve patient outcomes. Northland DHB will work towards different contracting arrangements for the provision of community pharmacist services by working with consumers and other stakeholders within the framework of the new contract to develop and agree some local service options for local priorities.

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 2014/15.

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

Reporting Entity:

Northland DHB's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions such as laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district's population of about 180,000.

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

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. Northland DHB is currently in the process of embedding the P3M3 framework to support our programme management.

Northland DHB's **clinicians** form an integral part of our management structures and processes, and are intimately involved in regional and national planning processes and innovation. They make it a priority to provide excellent educational opportunities for trainees at all levels of their careers.

Our commitment to **quality and safety** aligns with the national vision and includes:
- the Quality and Safety Plan
- 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
- 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.

Northland DHB has developed a ten-year Long Term Investment Plan (LTIP) setting out a proposed programme to develop our **fixed assets** and Integrated Family Health Centres across the district. Northland DHB is a Tier 2 Intensive Investment Agency under Treasury's Investment

Management and Asset Performance (IMAP) and has a Cabinet-approved Investor Confidence Rating of "C". This reflects our ability to manage our asset portfolio and to successfully deliver promised benefits. Steps are underway to improve our portfolio management capability across a range of projects including assets. ***NRHP***

Northland DHB received approval on 30 May 2017 from the Capital Investment Committee to develop a programme business case for a major redevelopment of Whangarei Hospital. The aim of the redevelopment will be to transform health services in Northland with a focus on service and campus redesign.

4.2 Building capability

Organisational culture, leadership and workforce development

Over the next three to five years the DHB will continue to work towards ensuring that: we have a workforce that equitably responds to the population health needs; we recruit, retain and develop a workforce that reflects our changing population; we foster a safe, well, engaged, enabled workforce supported by effective leadership.

To successfully enable and develop an effective workforce, we have a number of guiding strategies: the five strategic themes from the NZ Health Strategy Future Direction; the five Leadership Character capabilities in the State Services Commission Leadership Success Profile; the Northern Regional Health Plan; Northland Workforce Development Strategy; and our own organisational Values.

Cooperative developments (working with other organisations such as education and training providers).

Northland District Health Board continues to work collaboratively with external education and training organisations. Northland DHB has a two year organisational wide training programme, which uses a combination of in-house facilitators and external training providers. Many of the courses are available for our primary health partners. All training providers ensure training is aligned to our organisational Values and strategic direction.

4.3 Workforce

4.3.1 Healthy ageing workforce

Northland DHB has a Workforce Development Plan that supports the non-specialist workforce, particularly those working in Aged Residential Care and Home and Community Support Services.

A Northland DHB and ARC Workforce Collaborative plans and prioritises a joint Quality Improvement and Education Programme for the regulated and non-regulated workforce in the 24 ARC facilities within Northland DHB.

The planned activity for 2018/19 includes:

- the Health of Older People RN workforce working to top of scope
- the development of Health Pathways specific for the care of ARC residents
- educational opportunities for facilities that create an environment that is free from harm
- complete a stocktake of the current specialist and non-specialist workforce providing services for older people (Q3).

Under the pay equity settlement it was agreed to create incentives to help care and support workers gain qualifications.

HCSS providers are required by Northland DHB to regularly report the qualifications (levels 2, 3, 4) of their workforce. This is providing a picture of the non-regulated workforce and understanding the enablers and barriers to successful completion and progression.

4.3.2 Health literacy

Northland DHB is committed to further developing its response in Health Literacy. Where gaps exist in our knowledge and approach to health literacy Northland DHB is committed to:

- understanding health literacy as a system issue in our organisation
- reviewing our services from a health literacy perspective
- understanding and reducing the health literacy demands our organisation places on our consumers
- integrating health literacy into our systems and procedures
- providing health literacy training for our staff.

4.3.3 Midwifery workforce

Northland DHB will develop and implement strategies to improve recruitment and retention of midwives within its services through:

- promoting opportunities for new graduate employment throughout the region
- exploring opportunities with HWNZ for scholarships for new grads
- exploring "Grow your Own" midwives strategy
- developing the Māori midwifery workforce across DHB facilities and community midwifery workforces
- enabling advance practice skills through Northland DHB maternity education program
- reducing recruitment and retention issues to enable workforce stability
- equity of access to midwifery services across the region
- continuing the collaborative venture with AUT for student midwives
- enabling placements for new graduates
- explore the possibilities to support the community midwifery workforce in hard to staff, rural areas in particular the Kaipara
- promote and support midwives within the DHB's district who are not currently in practice to return to practice, by providing access to clinical experience and workforce training to assist with return to midwifery programmes.

4.3.4 Care Capacity Demand Management

Northland DHB is committed to the CCDM programme and has utilised the majority of the tools since its implementation in 2012. Over the next year the focus will be on:

- continuing to work closely with the Safe Staffing Healthy Workplace Unit and union partners
- consolidate the CCDM programme within the organisation
- reinstating the CCDM Council and maintaining the CCDM Operations Group
- developing the Integrated Operations Centre
- implementing the CCDM requirements of the NZNO MECA with the application of the immediate relief funding and additional CCDM and Trendcare roles
- developing a recruitment campaign in conjunction with the national programme
- revisiting the workload analysis process when renewed by the Safe Staffing Healthy Workplaces Unit
- continuing to update and develop new electronic tools utilised for CCDM ie Hospital At A Glance screen Trendcare, VRM plans, bed and staffing management tools
- embed the FTE calculations as an annual process.

4.4 Information technology

Northland's IT investments are planned, managed and delivered as one integrated portfolio. We work within the context of the Regional ISSP, using shared architecture and design resource, and leveraging regionally-funded and developed foundational infrastructure and capabilities wherever practical.

Initiatives in Northland's multi-year portfolio plan include:

The hospital paperlite programme which will see increased digitisation of clinical documentation and investigations, further deployment of electronic referrals, paperless ordering and signoff, and closed loop medications. These will leverage wherever possible capabilities which have already been built in the region.

Accelerated adoption of technologies which enable doing more on the move and greater integration of technology into clinical care and decision-making. Capability will be built within Northland, and through regional investment in foundational technologies.

The regional Jade replacement programme, on which Northland is the lead DHB, and the regional NCHIP and Clinical Workstation programmes.

The planning for the next tranche of initiatives after the hospital paperlite programme, including the potential to deploy tools such as eVitals.

Working within a large complex region presents both considerable opportunity and risk (for example that Northland's need to catch up and address urgent local digital priorities is subsumed within the wider priorities). Our key risk mitigation is to have the Northland plan aligned and integrated with the regional LTIP and ISSP as described above. Additionally, we are working together as a region to complete a review of the integrated governance structure which will oversee delivery of the ISSP. This structure will include appropriate involvement and decision-making from all DHBs at all levels – for example in design, planning, and delivery.

Proposed phasing of the initiatives described above:

Initiative	Outcome	Milestone date
Hospital paperlite programme	Business case Clinical Dictation	Dec 2018
	Automated integrations with WebPAS	Mar 2019
	Referral pathways inter / Intra	May 2019
	e-sign off deployment	June 2019
Enabling technologies	Identity and access management (IAM) detailed design complete	Jun 2019
	Workspace business case	Jan 2019
	Complete move of all integrations from JCAPS to MuleSoft	July 2019
	IaaS – initial workload and migration plan completed	Feb 2019
	IaaS – service establishment	Mar 2019
Jade replacement	RCCC draft detailed business case	Mar 2019

4.5 Other key initiatives

4.5.1 Innovation, Improvement and Excellence

The Innovation, Improvement and Excellence initiative started in April 2017. Its aim is to drive value in Northland Health Services to support the vision of Healthier Northlanders. While all our services aim at delivering the best care to all patients, we are aware that there are areas for improvement, in processes, outcomes or even cost. The Innovation, Improvement and Excellence team works with Northland DHB teams to identify opportunities for improvement, understand the problems, and design and implement solutions that enable the teams to deliver more value for the patients and for the population.

Our four main themes of work include:

Doing the right thing: Are we prioritising the most suitable projects or types of care? Can we deliver healthcare in a sustainable way, and how should the care offered evolve to adapt to environmental changes? To use the common metaphor of the ambulance at the bottom of the cliff, are we providing ambulance care or are we making the top of the cliff safer?

Doing it right: Can we provide healthcare in a more efficient way both for patients and for staff? This includes the Releasing Time to Care programme, as well as several initiatives within Outpatients and Theatres. We are also working on a production plan system which will provide better visibility of demand and supply, enabling the services to better plan and to reduce the need to turn to reactive solutions.

Driving a culture of value: The change can't be achieved by a small team. We are taking every opportunity to drive a cultural change that will see all staff empowered to suggest and to lead improvements, small and big. This will happen through training, coaching, and with a leadership model based on trust and development of staff at all levels.

Enabling with data analysis: Working closely with the Health Intelligence Hub, the Innovation, Improvement and Excellence team supports the move from descriptive analysis towards predictive and prescriptive analysis, as well as better availability, transparency and visualisation of operational data.

4.5.2 Māori Health Community Services Review

There is an increasing emphasis on the achievement of health outcomes for Māori Whānau which has a focus on the 'ends' rather than the means of service provision. The process therefore includes designing and procuring outcomes rather than services to be provided, and compensating Māori NGOs based on progression towards the achievement of health outcomes. It has been ten or so years since Māori health community services were reviewed and although there has been improvement in Māori population health there still remains a gap between Māori and non-Māori. Additionally, population health priorities have changed in this period of time. Our focus is to work closely with our Māori health providers to collectively consider how services are shaped to meet a changing need for Māori living in Northland. Consumer feedback will also be sought to ensure their voice is heard and the process allows for active input into the final design of Māori health community services across Te Taitokerau. This project will completed by December 2018 and implemented by July/ August 2019.

4.5.3 Māori Priorities Development

The review is about allowing Northland Māori and the wider community to have their say and come forth with ideas that will help shape the key priorities for the district. These priorities will then guide the establishment of a commissioning framework for Māori health and how we invest and measure long term performance that leads to a reduction in the population target for Māori health life expectancy. The last known Māori health strategy was published in 2009 and developed by a network of Māori health providers from Te Taitokerau. The strategy expired in 2013 with the only other reference point for Māori health and Whānau Ora being the Northland Health Services Plan 2012-2017. Our process will include a two month period where we will workshop these ideas with our Māori community. These priorities will then guide the establishment of a commissioning framework for Māori health and how we invest and measure long term performance that leads to a reduction in the population target for Māori health life expectancy. The project is expected to be completed by February 2019.

4.5.4 Health Intelligence

Northland DHB has built on past analytical work to establish the Health Intelligence Hub. The Hub is currently developing a online health needs assessment that will be interactive and flexible. The HNA tool will have various layers and components to suit different audiences and purposes, from health services of various types, to ELT, and potentially to the wider public. The electronic format will enable data to be updated at any time. The HNA will be used initially for our strategic planning process, and the tool's visibility will make it valuable for engaging in discussions about health

needs and needs-based planning. The Health Intelligence Hub is also developing a dashboard and scorecard for ELT so they can better monitor Northland DHB's progress and achievements.

4.5.5 Whangarei Hospital Site Master Plan

Whangarei Hospital, the hub of secondary services in Northland, is outdated and no longer fit for purpose. Apart from structural problems associated with asbestos, subsidence and ageing infrastructure, many buildings have inflexible layouts that adversely affect patient flows and limit our plans for new, contemporary models of care. The current buildings cannot accommodate new services which would reduce the need for patients to travel to other DHBs for treatment. In recent years short-term patch-ups have been repeatedly made to keep the facilities functional, while longer-term costs, such as deferred maintenance and system deterioration, have built up.

There are growing risks of clinical failure from lack of capacity to meet the growing demand for services, an ageing population (compared to the rest of the country, proportionally one of the largest and growing more quickly), and the difficulty we experience in recruiting some specialist staff. We need to improve access, timeliness and quality of care to reduce avoidable mortality, and improve equity and life expectancy, particularly for Māori.

We know we need to do things differently. We will take a transformational investment path to create an environment of redesigned, innovative health service delivery, provided in fit-for-purpose facilities. This will include up-to-date clinical equipment, and an integrated Information and Communications Technology (ICT) infrastructure that supports and enables right-place / right-time and clinical decision-making, in both hospital and community settings. The new clinical services will be designed to fit with developments in the wider health care system.

Following the approval of the Transforming Health Services in Northland: Service and Campus Redesign Strategic Assessment Business Case in May 2017 by the Capital Investment Committee Northland DHB has prepared a Programme Business Case outlining the investments proposed for the period 2018 to 2034. This is the second stage in a five stage Better Business Case process adopted by Treasury under Cabinet Office Circular (CO (15)5). .A funding decision is to be made no earlier than the last half of 2019.

4.5.6 Telehealth and Mobility

Northland's Telehealth and Mobility Programme is accelerating adoption of enabling technologies and changing the way healthcare is delivered. Doing more on the move will improve productivity, achieve more and better ways of working remotely, promote and manage the expanding clinical use of communications technology (telehealth) and its integration into clinical care, and rapidly expand the use of mobile access to clinical information across community and hospital based services. Rather than wait for new technologies to emerge and be adopted more widely, Northland DHB is trying to 'polevault' our current position by identifying quick wins that deliver real clinical value.

4.5.7 Strategy

Northland DHB is currently developing a Strategy for the future direction of health services in Northland. It will be health sector-wide, not DHB centric. It will be a high level roadmap that sets out the district's strategic health themes and decision making principles. The Strategy will be a guiding document that will enable the alignment and strengthening of existing strategic plans of organisations and services, and prompt the development of new plans to fill gaps. The Strategy draws upon plans that exist locally, regionally and nationally, and it will be consistent with the NZ Health Strategy, NZ Disability Strategy and the Northern Region Long Term Investment Plan.

So far stakeholders have been identified, a first draft of strategic themes formulated, and an engagement process and communications plan will be developed. The intention is to publish the Strategy in the early months of the new year.

5 Performance measures

Key:	
	Targets set nationally by the Ministry of Health.
	Targets negotiated between the Ministry and Northland DHB.

Performance measure			Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy			Quarterly highlight report against NZHS themes.	
PP6: Improving the health status of people with severe mental illness through improved access	Ages 0-19		Total 4.63% Māori 5.01%	
	Ages 20-64		Total 5.70% Māori 9.24%	
	Ages 65+		Total 2.30% Māori 2.38%	
PP7: 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.	
			Report on activities in the Annual Plan.	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds			80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
			Report on activities in the Annual Plan.	
PP10: Oral Health- Mean DMFT score at Year 8	Year 1		0.91	
	Year 2		0.91	
PP11: Children caries-free at five years of age	Year 1		46%	
	Year 2		46%	
PP12: Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17)	Year 1		95%	
	Year 2		95%	
PP13: Improving the number of children enrolled in DHB funded dental services	Children enrolled ages 0-4		Year 1	≥95%
			Year 2	≥95%
	Enrolled preschool and primary school children overdue for their scheduled examinations		Preschool	≤10%
			Primary school	≤10%

PP20: Improved management for long term conditions	Focus Area 1: Long term conditions	Report on activities in the Annual Plan.
	Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.
		Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).
	Focus Area 3: Cardiovascular health	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.
		90% of eligible Māori men in the PHO aged 35-44 years have had their cardiovascular risk assessed in the past 5 years.
	Focus Area 4: Acute heart service	>70% of high-risk patients receive an angiogram within 3 days of admission.
		Over 95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and ≥99% within 3 months.
		≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF.
	Focus Area 4: Acute heart service (continued from previous page)	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes). Target >85% (see FAQs).
	Focus Area 5: Stroke services	10% or more of potentially eligible stroke patient's thrombolysed 24/7.
		80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.
		80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.
		60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team (ie RN/ PT/ OT/ SLT /SW/ Dr/ Psychologist) within 7 calendar days of hospital discharge.
PP21: Immunisation coverage		95% of two year olds fully immunised.
		95% of four year olds fully immunised.
		75% of girls fully immunised – HPV vaccine.
		75% of 65+ year olds immunised – flu vaccine.
		Report on activities in the Annual Plan.
PP22: Delivery of actions to improve system integration including SLMs		Report on activities in the Annual Plan.
PP23: Implementing the Healthy Ageing Strategy		Report on activities in the Annual Plan.
		Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4-6 for assessment urgency. Baseline to be established.
PP25: Youth mental health initiatives		Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.
		Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).
		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.

PP26: The Mental Health & Addiction Service Development Plan		Provide reports as specified for the focus areas of: primary mental health district suicide prevention and postvention improving crisis response services improving outcomes for children improving employment and physical health needs of people with low prevalence conditions.
PP27: Supporting child wellbeing		Report on activities in the Annual Plan.
PP28: Reducing rheumatic fever		Reducing the Incidence of First Episode Rheumatic Fever. Target ≤3.5 per 100,000.
PP29: Improving waiting times for diagnostic services		95% of accepted referrals for elective coronary angiography will receive their procedure within 90 days.
		95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).
		90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.
		70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.
PP30: Faster cancer treatment		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
		Report on activities in the Annual Plan.
PP31: Better help for smokers to quit in public hospitals		95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.
PP32:Improving the quality of ethnicity data collection in PHO and NHI registers		Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PP33: Improving Māori enrolment in PHOs		Meet and/or maintain the national average enrolment rate of 90%.
PP36: 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.
PP37: Improving breastfeeding rates		70% of infants are exclusively or fully breastfed at three months.
PP39 Supporting Health in Schools		Report on activities in the Annual Plan.
PP40 Responding to climate change		Report on activities in the Annual Plan.
PP41 Waste disposal		Report on activities in the Annual Plan.
PP43 Population mental health		Report on activities in the Annual Plan.
PP44 Maternal mental health		Report on activities in the Annual Plan.
PP45 Elective surgical discharges		Previous Health Target. Target 9,146.
SI1: Ambulatory sensitive hospitalisations	Ages 0-4	In Appendix B: System Level Measures Improvement Plan
	Ages 45-64	By 30 June 2019, reduce the equity gap between the Northland Māori rate (7,612/100,000 as at Dec 2017) and the Northland other rate (3,129/100,000) by 5%, that is from 4,483 to 4,259.
SI2: Delivery of Regional Plans		Provision of a progress report on behalf of the region agreed by all DHBs within that region *[to be provided by the Northern Regional Alliance]*.
SI3: Ensuring delivery of Service Coverage		Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the

		Ministry).	
SI4: Standardised Intervention Rates (SIRs)		Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population.	
		Cataract procedures - a target intervention rate of 27 per 10,000 of population.	
		Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.	
		Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.	
		Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.	
SI5: Delivery of Whānau Ora		Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita		In Appendix B: System Level Measures Improvement Plan	
SI8: SLM patient experience of care		In Appendix B: System Level Measures Improvement Plan	
SI9: SLM amenable mortality		In Appendix B: System Level Measures Improvement Plan	
SI10: Improving cervical screening coverage		80% coverage for all ethnic groups and overall.	
SI11: Improving breast screening rates		70% coverage for all ethnic groups and overall.	
SI12: SLM youth access to and utilisation of youth appropriate health services		In Appendix B: System Level Measures Improvement Plan	
SI13: SLM number of babies who live in a smoke-free household at six weeks postnatal		In Appendix B: System Level Measures Improvement Plan	
SI14: Disability support services		Report on activities in the Annual Plan.	
SI15: Addressing local population challenges by life course		Report on activities in the Annual Plan.	
SI16: Strengthening Public Delivery of Health Services		Report on activities in the Annual Plan.	
SI17: Improving quality		Report on activities in the Annual Plan.	
SI18: Improving newborn enrolment in general practice	By 6 weeks of age	55% of newborns enrolled in general practice.	
	By 3 months of age	85% of newborns enrolled in general practice.	
		Report on activities in the Annual Plan.	
OS3: Inpatient length of stay		Elective LOS suggested target is 1.45 days, which represents the 75th centile of national performance.	
		Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	
OS8: Reducing Acute Readmissions to Hospital		3.1%	
OS10: 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 registrations	>0.5% and ≤2%
		Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and ≤2%
		Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and ≤85%

		Invalid NHI data updates	TBA
	Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	≥97% and <99.5%
		National Collections File load Success	≥98% and <99.5%
		Assessment of data reported to NMDS	≥75%
		Timeliness of NNPAC data	≥95% and <98%
	Focus Area 3: Improving the quality of PRIMHD	Provide reports as specified about data quality audits.	
Output 1: Mental health 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.	

Appendix A: Statement of Performance Expectations

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

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

Key Assumptions for Financial Statements

Revenue Growth

The majority of Northland DHB's revenue is from the Ministry of Health, made up mostly of population-based funding for the Northland DHB population, IDF revenue (for services delivered for other DHB's populations). The Ministry of Health advised us in May 18 of a PBFF funding increase of $35m.

Expenditure Growth

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

Capital Expenditure

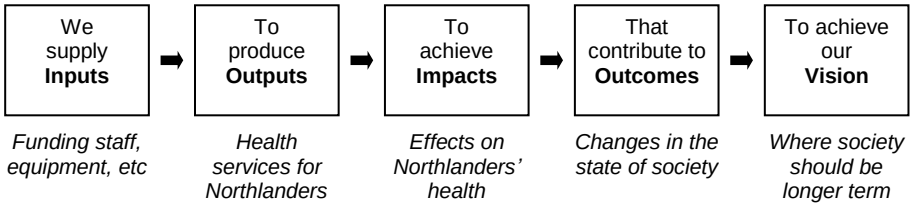
Capital expenditure is for remediation of baseline infrastructure, upgrades, investment in new technology and clinical equipment replacement. Crown funding will be required to finance major redevelopment and upgrade projects.

Output classes and intervention logic

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 the population. These services improve the health status of the population, as distinct from curative services (the other three output classes) which repair or support illness or injury.
Early detection and management	Commonly referred to as 'primary' or 'community' services, those that people can access directly in the community. They are delivered by a range of agencies 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 based support services, residential care and services for dementia) and palliative care services.

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



The structure of the SPE is described in the diagram on the next page.

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

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

Wherever possible, Impacts are measured by Māori and non-Māori so, consistent with the Population Health aim, we can monitor inequities and reduce these over time.

Summary of Northland DHB's Statement of Performance Expectations 2018/19

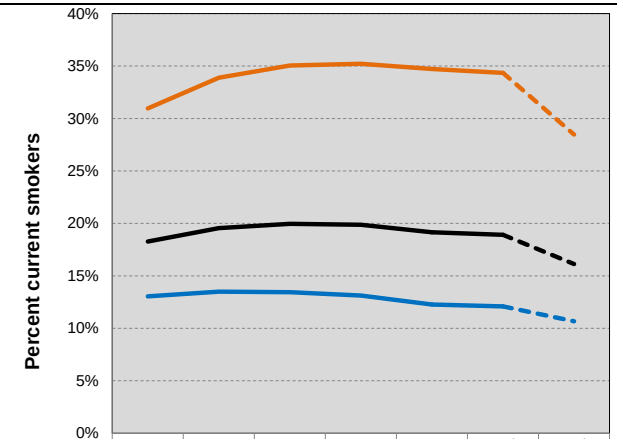
Vision	A healthier Northland									
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities	Patient experience: patients and Whānau experience clinically and culturally safe, good quality, effective, efficient and timely care				Value and sustainability: 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 annually 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	**Elective surgery** Fewer debilitating conditions, delayed onset of long term conditions	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	% of adults who are current smokers	Full and exclusive breastfeeding at 3 months % of 8-month-olds who have their primary course of immunisation on time Average number of decayed, missing or filled teeth in Y8 students % of 4-year-olds identified as obese will be offered a referral to a health professional	Ambulatory sensitive hospitalisations, rate/100,000 ages 0-4	Good blood sugar management in diabetics Eligible people receiving cardiovascular (CVD) risk assessment in the last 5 years	Breast cancer screening in eligible (aged 50-69) populations Cervical cancer screening in eligible (aged 25-69) populations Urgently referred patients with a high suspicion of cancer who receive their first cancer treatment within 62 days	% of people with enduring mental illness aged 20-64 who are seen over a year	Increase in elective surgical discharges	95% of patients will be admitted, discharged or transferred from and ED within 6 hours	Falls causing harm in NDHB facilities Pressure injuries in NDHB facilities Surgical safety compliance Hand hygiene compliance Medicines reconciled	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 Quit Card Providers Advice and help offered to smokers in hospital	Midwifery services Support by lactation consultants Oral health assessment and treatment Immunisations in primary care 4-year-olds given Before School Checks (B4SC)	Acute hospital services	Assessment, diagnosis and treatment in primary care	Eligible women screened for breast cancer Eligible women screened for cervical cancer Cancer risk assessments in primary care Provision of cancer therapies	Specialised clinical support by NDHB community mental health services Admission to hospital for those whose condition is acutely unwell	Elective surgical procedures	Assessments, and treatments performed in EDs	Leadership, advice and monitoring by Quality Improvement Directorate Effective clinical services Patient pathways, hospital discharge processes	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	People attending primary care who have ever smoked	Hospital births Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care B4SC performed	Acute hospital discharges	Risk assessments and monitoring of people with diabetes and/or CVD	Screening for breast and cervical cancer Referrals for radiotherapy and chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Increase in the volume of elective surgery	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

Key: Yellow highlights = Health Targets. All measures to be by Māori and non-Māori where data is available.

Output Class 1: Prevention

Impact: Lower prevalence of smoking-related conditions.

Measure: % of Northland adult population who are current smokers



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 to Q2	2018/19 target
Total	18.3%	19.6%	20.0%	19.9%	19.2%	18.9%	16.1%
Maori	31.0%	33.9%	35.1%	35.2%	34.7%	34.3%	28.5%
Non-Maori	13.1%	13.5%	13.4%	13.1%	12.3%	12.1%	10.7%

Measure type: Coverage

Rationale

Smoking and obesity are the two most significant factors behind long term conditions. Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birthweight babies.

Currently, according to data from the Northland PHOs, 34% of Māori and 12% of non-Māori smoke.

Smoking rates are the focus of one of the six national Health Targets. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.

The dotted lines in the graph reflect the percentage drop required by each ethnic group to reach the 2025 target. Non-Māori smoking rates are reducing at close to the desired rate, but Māori smoking rates need to decline faster.

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

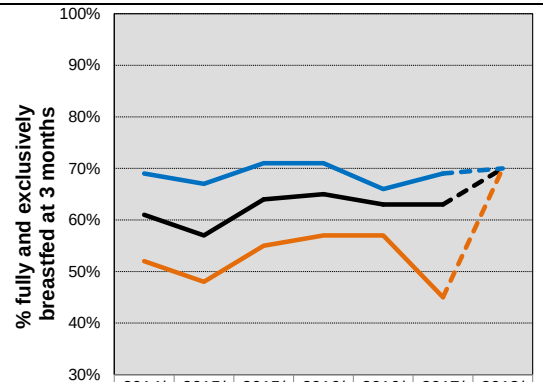
Outputs

Primary care records show 111,008 Northlanders who have ever smoked, of whom 24,211 are current smokers (2017/18 Q3).

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

Measure: Full and exclusive breastfeeding at 3 months

Measure type: Coverage



	2014/15 Q3	2015/16 Q1	2015/16 Q3	2016/17 Q1	2016/17 Q3	2017/18 Q1	2018/19 target
Total	61%	57%	64%	65%	63%	63%	70%
Maori	52%	48%	55%	57%	57%	45%	70%
Non-Maori	69%	67%	71%	71%	66%	69%	70%

Rationale

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

Breastfeeding rates are lower among Māori.

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

Outputs

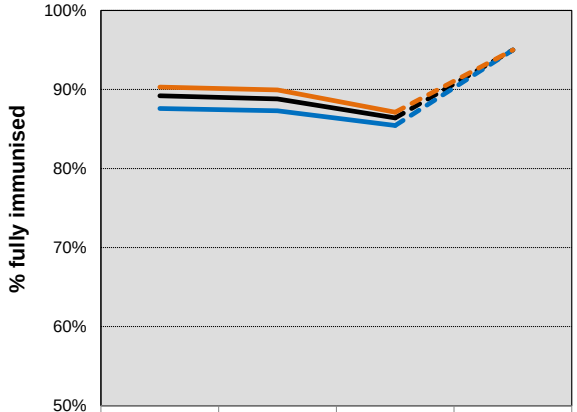
Total Northland DHB hospital births: 1,974 for the twelve months ending March 2017.

3,188 lactation consultant patient contacts for the twelve months ending March 2017.

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 Northland DHB midwife (hospital births).

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

Measure type: Coverage



	2015/16	2016/17	2017/18 to Q3	2018/19 target
Total	89.2%	88.8%	86.4%	95.0%
Non-Maori	87.6%	87.3%	85.4%	95.0%
Maori	90.3%	89.9%	87.1%	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.

One of the six national Health Targets.

Encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage. The High Five Project as part of the First 2000 Days Project aims to have all newborns enrolled in five key services: general practice, National Immunisation Register, Well Child/ Tamariki Ora provider, oral health, Newborn Hearing Screening.

Outputs

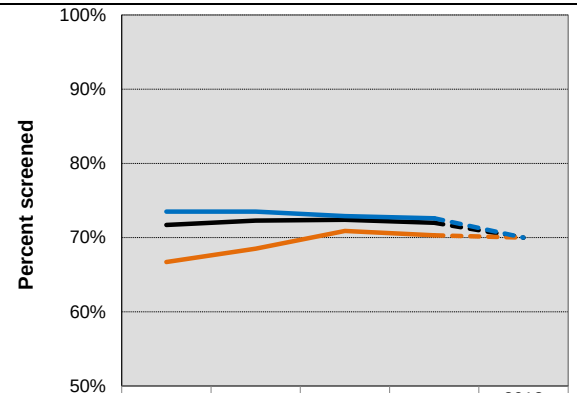
2,005 children were fully immunised before 8 months of age during the twelve months ending March 2018.

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

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

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

Measure type: Coverage



	2014	2015	2016	2017	2018 target
Total	71.7%	72.3%	72.4%	72.0%	70.0%
Maori	66.7%	68.5%	70.9%	70.3%	70.0%
Non-Maori	73.5%	73.5%	72.9%	72.6%	70.0%

Rationale

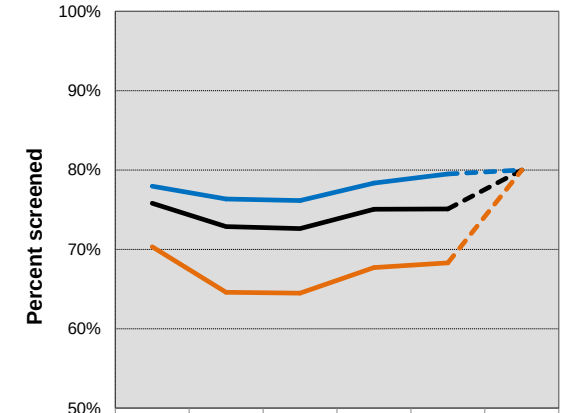
Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. The only two formal screening programmes that exist in New Zealand are for breast cancer and cervical cancer.

Outputs

9,007 eligible women were screened in calendar year 2017, including 2,705 Māori and 6.902 non-Māori.

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

Measure type: Coverage



	2013/14	2014/15	2015/16	2016/17	2017/18 to Q1	2018/19 target
Total	75.8%	72.9%	72.6%	75.1%	75.1%	80.0%
Maori	70.3%	64.6%	64.5%	67.7%	68.3%	80.0%
Non-Maori	78.0%	76.4%	76.2%	78.3%	79.5%	80.0%

Outputs

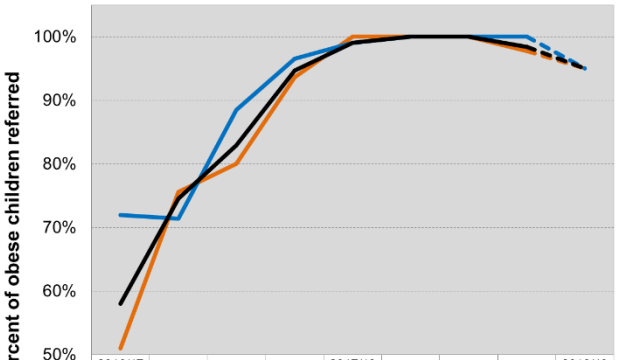
32,328 eligible women screened in the three years up to Dec 2017, of whom 9,040 were Māori and 23,288 were non-Māori.

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 will be offered a referral to a health professional

Measure type: Coverage



	2016/17 Q1	Q2	Q3	Q4	2017/18 Q1	Q2	Q3	Q4	2018/19 target
Maori	51%	76%	80%	94%	100%	100%	100%	98%	95%
Non-Maori	72%	71%	88%	97%	99%	100%	100%	100%	95%
Total	58%	75%	83%	95%	99%	100%	100%	98%	95%

Rationale

Obesity, along with smoking, is the most significant factor behind long term conditions.

It disproportionately affects Māori and other deprived populations. The 2011-14 NZ Health Survey showed that in Northland obesity affects 50% of Māori and 28% of non-Māori.

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.

- One of the six national Health Targets. It has been in place for only two years, hence the quarterly breakdown.

Outputs

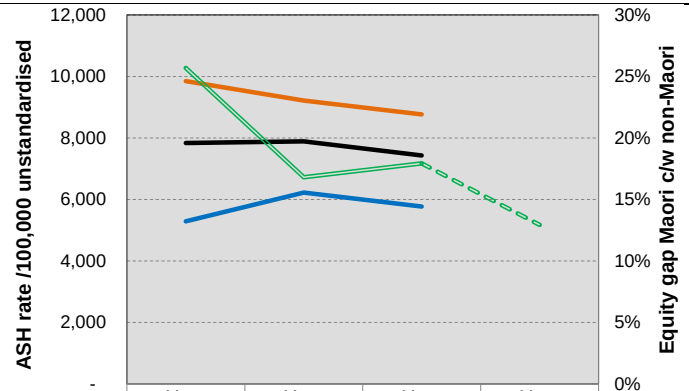
1,917 4-year-olds checked in the eleven months from June 2017 to May 2018, of whom 1,032 were Māori and 885 non-Māori.)

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

Measure:

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

Measure type:
Quality



	Year ending Dec 2015	Year ending Dec 2016	Year ending Dec 2017	Year ending Dec 2018
Total	7,835	7,891	7,432	
Maori	9,848	9,218	8,765	
NMNP	5,288	6,224	5,769	
Equity gap	26%	17%	18%	13%

Target setting for this measure relates to the equity gap (the percentage difference between the Māori and non-Māori rates) and is consistent with the 5% reduction in the in our System Level Measure plan. The numbers differ however from those in the SLM plan because the time periods covered are different.

Rationale

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

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

Lower rates of ASH free up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar. Achieving this involves managing the complex interface between primary and secondary care, for which Northland DHB has a number of initiatives in place or planned. For example, Northland DHB is trialling an enhanced Primary Options service to enable GPs to flexibly develop management plans for their patients and thus avoid hospital admissions. Information gleaned from the trial will inform the creation of a new rapid response and stabilisation service.

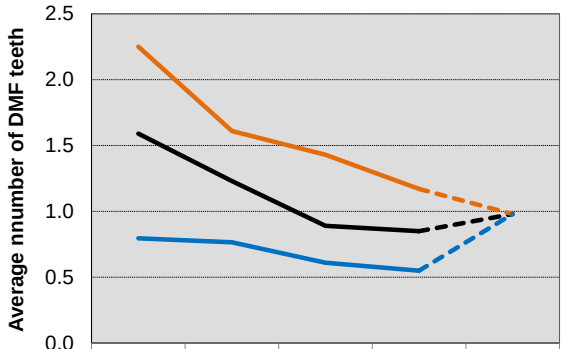
Outputs

Total acute discharges of Northland residents from any hospital (Northland DHB and other DHBs) 2016/17: total 23,818, Māori 8,176, non-Māori 15,642.

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

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

Measure type:



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

Rationale

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

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

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

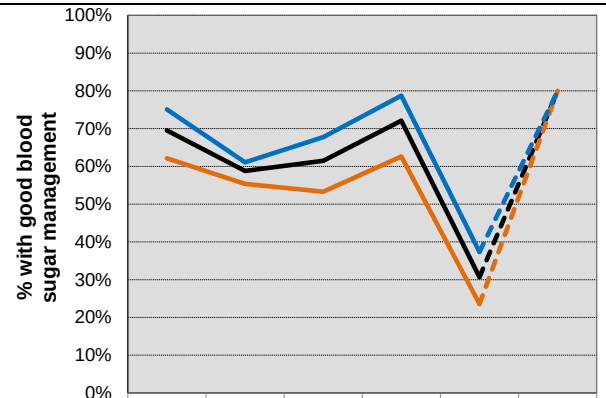
Outputs

1,246 Year 8 students were treated by Northland DHB's services in the 2017 calendar year.

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

Measure: Good blood sugar management in diabetics

Measure type: Coverage



	2013/14	2014/15	2015/16	2016/17	2017/18 Q2	2018/19 target
Total	69.5%	58.8%	61.5%	72.1%	30.7%	80.0%
Maori	62.2%	55.4%	53.3%	62.6%	23.5%	80.0%
Non-Maori	75.1%	61.1%	67.8%	78.7%	37.4%	80.0%

Repeated changes to how this measure is calculated meant that the 2017/18 result cannot be compared with previous years.

Rationale

Diabetes is an increasingly common long term condition.

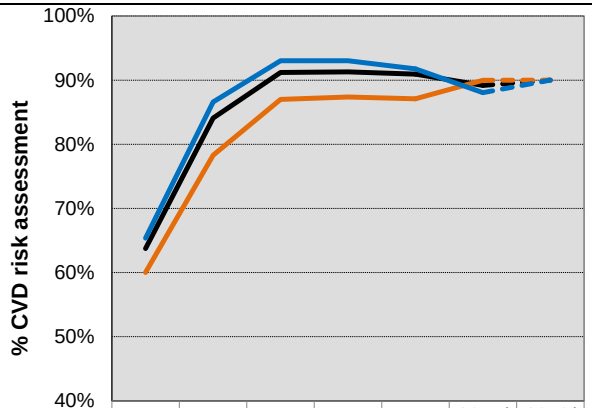
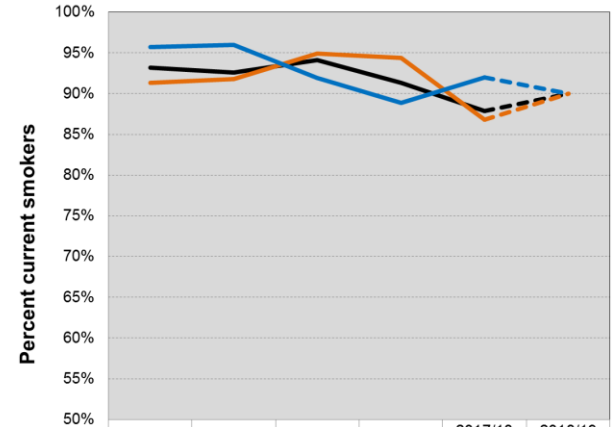
It is strongly associated with excess weight, which affects a disproportionate number of Northlanders. Prevalence also increases with age, so prompt action is imperative in the face of the ageing population.

It is a major cause of illness and a significant contributor to cardiovascular disease.

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.

Outputs

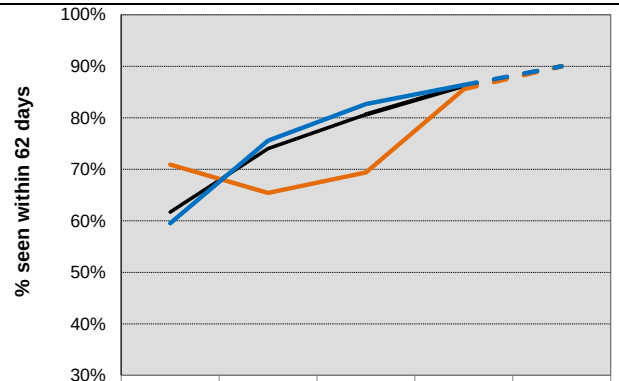
As at Sep 2017, 9,458 people are on the Northland diabetes register, of whom are 4,028 Māori and 5,430 are non-Māori.

Measure: Eligible people receiving cardio-vascular (CVD) risk assessment in the last 5 years **Measure type:** Coverage	 2012/13 · 2013/14 · 2014/15 · 2015/16 · 2016/17 · 2017/18 to Q3 · 2018/19 target Total: 63.7% · 84.1% · 91.2% · 91.3% · 90.9% · 89.2% · 90.0% Maori: 60.0% · 78.3% · 87.0% · 87.4% · 87.1% · 90.0% · 90.0% Non-Maori: 65.4% · 86.6% · 93.0% · 93.0% · 91.8% · 88.0% · 90.0%	**Rationale** Along with cancer, cardiovascular (heart and circulatory) disease is the most common long term condition. Prevalence of CVD conditions increases with age. The ageing population means we need to carefully monitor and control the incidence and severity of these conditions. Regular screening identifies those at risk of developing cardiovascular disease, and its onset can be prevented or delayed by lifestyle and clinical interventions. Regular screening also helps earlier identification of those who already have the condition.	**Outputs** 53,025 CVD risk assessments performed in primary care over the five years to Mar 2018, of whom 17,155 were Māori, Pacific or Indian (the latter are a high-risk group for heart disease).
Measure: % 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 **Measure type:** Coverage	 2013/14 · 2014/15 · 2015/16 · 2016/17 · 2017/18 to Q2 · 2018/19 target Total: 93.2% · 92.6% · 94.1% · 91.3% · 87.8% · 90.0% Maori: 91.3% · 91.8% · 94.9% · 94.4% · 86.8% · 90.0% Non-Maori: 95.7% · 96.0% · 91.9% · 88.8% · 92.0% · 90.0%	**Rationale** Smoking and obesity are the two most significant factors behind long term conditions. Smoking during pregnancy accounts for an estimated 20% of all pre-term births and 35% of low birth weight babies. Smoking rates are the focus of one of the six national Health Targets. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.	**Outputs** Total Northland DHB hospital births: 1,974 for the twelve months ending March 2017.

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 their first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks



	2014/15	2015/16	2016/17	2017/18 Q2	2018/19 target
Total	61.7%	74.0%	80.7%	86.2%	90.0%
Maori	70.9%	65.4%	69.4%	85.6%	90.0%
Non-Maori	59.5%	75.6%	82.7%	86.4%	90.0%

Measure type:
Coverage

Rationale

Along with cardiovascular disease, cancer is the most common long term condition.

For cancer, some of the biggest gains are to be made by ensuring early access to treatment to improve the chances of recovery or to alleviate symptoms.

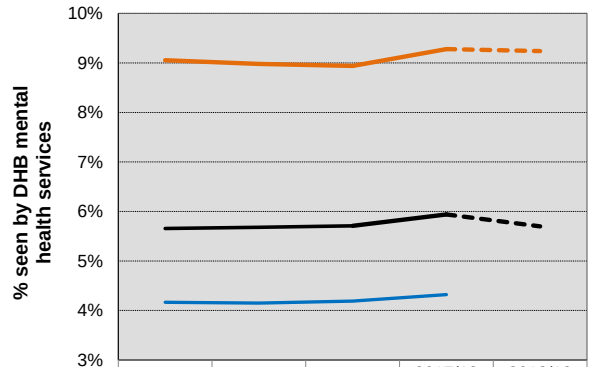
Outputs

283 patients referred urgently with high suspicion of cancer for the twelve months ending March 2018 who commenced first treatment.

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

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

Measure type: Coverage



	2014/15	2015/16	2016/17	2017/18 Q2	2018/19 target
Total	5.66%	5.68%	5.71%	5.94%	5.70%
Maori	9.06%	8.98%	8.94%	9.28%	9.24%
Non-Maori	4.17%	4.15%	4.19%	4.32%	

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

Rationale

Severe disorders permanently affect 3% of the population.

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

Mental health has been a priority for the health sector since the Mental Health Blueprint was published in 1998; that has since been overtaken by *Rising to the Challenge*, the national mental health and addictions strategy 2012-2017.

Outputs

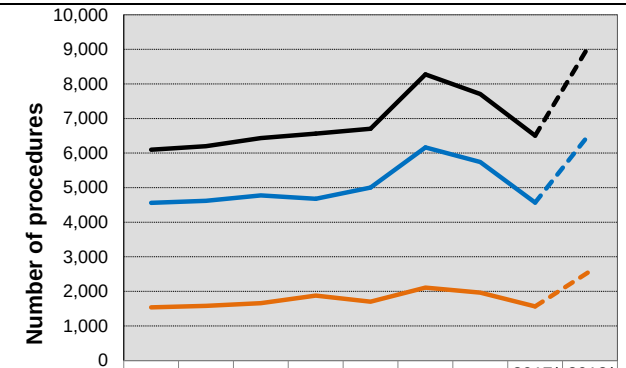
Number of contacts by community mental health services with people who have enduring mental illness (2017/18 extrapolated from 9 months data):

Direct (with client and/or Whānau)	95,000
Care coordination (on behalf of client, with another agency)	18,500

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

Measure: Increase in the volume of elective surgery

Measure type: Coverage



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 to Q3	2018/19 target
Total	6,098	6,198	6,434	6,564	6,704	8,275	7,707	6,503	9,146
Maori	1,537	1,580	1,660	1,877	1,702	2,110	1,965	1,564	2,581
Non-Maori	4,561	4,618	4,774	4,677	5,002	6,165	5,742	4,568	6,565

Rationale

Elective surgery is an effective way of increasing people's functioning because it remedies or improves conditions that restrict people's functioning.

Increasing delivery will improve access and reducing waiting times as well as increase public confidence that the health system will meet their needs.

Timely access to elective services is considered by the Ministry of Health to be a measure of the effectiveness of the health system.

One of the six national Health Targets.

Outputs

Target elective surgical discharges in 2018/19 is 9,146, of which 6,565 are non-Māori and 2,581 are Māori.

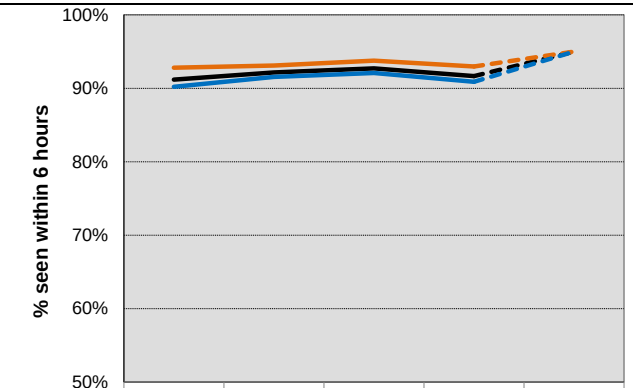
The data used here represents the targets set in each year's Annual Plan. These numbers do not represent total extra elective surgical discharges because every year MoH provides more funding for more procedures, and those amounts cannot be predicted. The most rational way of assessing Northland DHB's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

Note: targets for 2018/19 are provisional.

Impact: More timely assessment, referral and treatment

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

Measure type: Timeliness



	2014/15	2015/16	2016/17	2017/18 to Q3	2018/19 target
Total	91.2%	92.2%	92.7%	91.7%	95.0%
Maori	92.8%	93.1%	93.8%	93.0%	95.0%
Non-Maori	90.2%	91.6%	92.1%	90.9%	95.0%

Rationale

ED length of stay 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; the timeliness of treatment delivery. and any time spent waiting, is 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 lengths of stay
- overcrowding can also lead to compromised standards of privacy and dignity for patients (for example if corridor trolleys are needed to accommodate patients).

One of the six national Health Targets.

Outputs

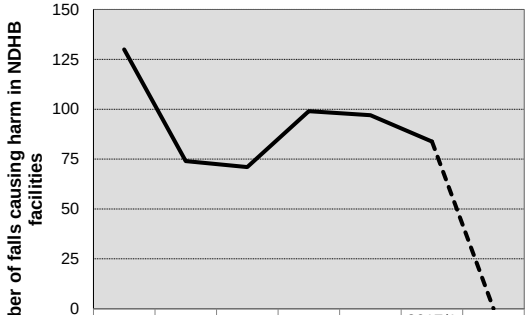
Emergency services provided by EDs at Whangarei Hospital, Northland DHB's most specialised ED, as well as satellite services at the other three hospitals in Kaitaia, Kawakawa and Dargaville.

Emergency department attendances for the year ended 2017/18 Q3 40,845.

Impact: Fewer adverse clinical events.

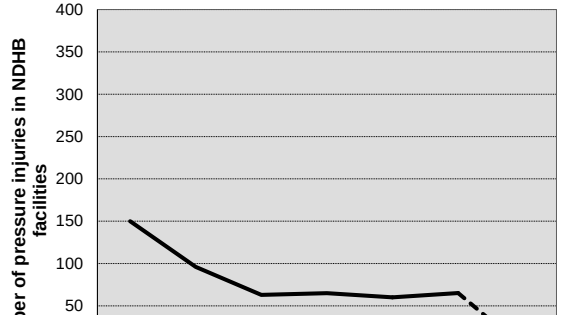
Measures type: Quality

Falls causing harm in NDHB hospitals



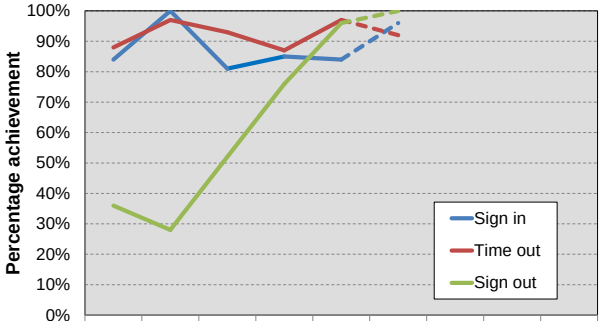
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 (Q3 extrap.)	2018/19 target
Harm from falls while in hospital	130	74	71	99	97	84	0

Pressure injuries in NDHB facilities



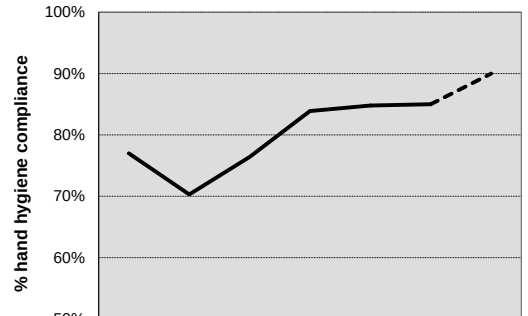
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 (Q3 extrap.)	2018/19 target
Pressure injuries	150	96	63	65	60	65	0

Surgical safety compliance



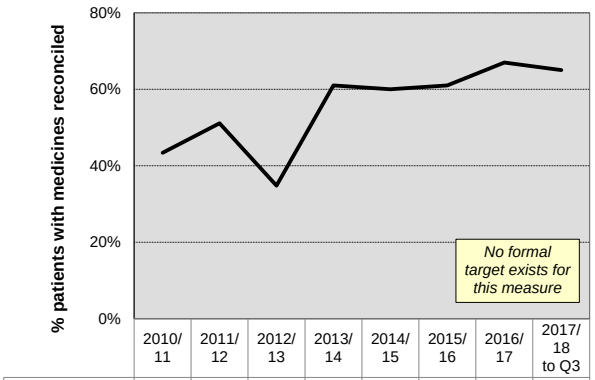
	2016/17 Q1	Q2	Q3	Q4	2017/18 Q1	Q2	Q3	Q4	2018/19 target
Sign in	84%	100%	81%	85%	84%	96%			100%
Time out	88%	97%	93%	87%	97%	92%			100%
Sign out	36%	28%	52.00	76.00	96%	100%			100%

Hand hygiene compliance



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 to Q3	2018/19 target
Hand hygiene compliance	77.0%	70.3%	76.4%	83.9%	84.8%	85.0%	90.0%

Medicines reconciled



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18 to Q3
Reconciliations completed	43.4%	51.1%	34.8%	61%	60%	61.0%	67.0%	65.0%

Legend components:

Sign in: checks before surgery begins (patient identification, site of operation, allergies, anaesthetic checklist etc.).

Time out: confirmation of operation details, possible concerns or unexpected steps, etc.).

Sign out: instrument checks, specimens labelled, future plans etc.).

Rationale

In the last decade considerable efforts have been made to improve the safety of healthcare. We know that if we cannot measure safety outcomes we cannot manage them, hence Northland DHB is actively working toward measuring outcomes as indicators of success.

These measures comprise key areas of known patient harm. They are reported to the Board and Clinical Governance on a monthly basis.

Outputs

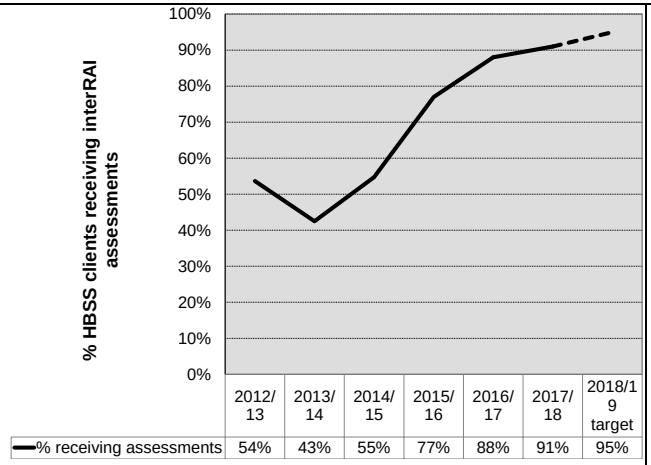
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Advisor.

Output Class 4: Rehabilitation and Support

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

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

Measure type: Coverage



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19 target
% receiving assessments	54%	43%	55%	77%	88%	91%	95%

Rationale

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

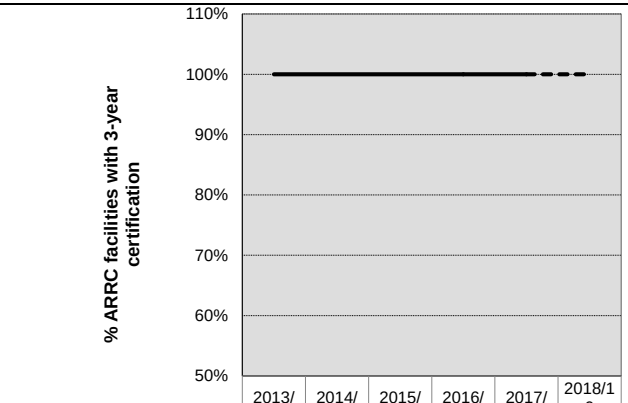
interRAI is collaborative network of researchers in over 30 countries who promote evidence-based clinical practice and policy to improve health care for persons who are elderly, frail, or disabled. InterRAI has developed assessment instruments for a range of populations in various areas of health care, including but not limited to home care and long term care facilities.

Outputs

1,951 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 2017.

Measure: % of HCSS providers certified

Measure type: Quality



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19 target
% HBSS providers certified	100%	100%	100%	100%	100%	100%

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.

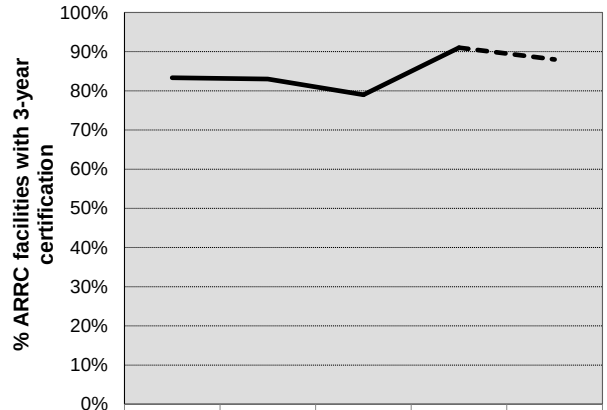
All Northland DHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2175 people in the community up to Dec 2017.

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

Measure type: Quality



	2014/15	2015/16	2016/17	2017/18	2018/19 target
% certified	83%	83%	79%	91%	88%

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 2017/18 there are 24 facilities, of which 1 has new owners. Because new owners automatically receive a one-year certification irrespective of their quality of service, they aren't counted in the performance data. Of the remaining 23, 15 have 3-year certification and 6 have 4-year; 21/23 = 91%.

Financial Performance Summary

Statement of Financial Performance - By Output Class $000s	Intensive Assessment & Treatment	Early Detection & Management	Prevention	Rehabilitation & Support Services	Budget 2018/2019
DHB Provider Revenue	320,174	27,095	2,787	10,606	360,663
Other Provider Revenue	8,293	6,628	11,135	4,170	30,226
DHB Funder Revenue	90,962	121,663	10,712	69,647	292,985
Total SOI Revenue	419,430	155,386	24,634	84,423	683,873
Personnel Costs					
Medical Labour	68,317	6,815	1,531	34	76,698
Nursing Labour	85,071	7,751	1,900	5,102	99,823
Allied Health Labour	25,796	11,933	2,654	2,703	43,086
Non Clinical Support Labour	5,004	166	129	83	5,381
Management and Admin Labour	26,584	3,807	2,580	1,668	34,640
Non-Personnel Operating Costs					
Outsourced Services	23,006	3,354	978	607	27,946
Clinical Supplies	46,586	2,025	604	2,627	51,842
Infrastructure and Non Clinical	36,641	4,129	1,723	1,957	44,450
Finance and Capital Costs	7,333	776	272	360	8,741
Provider Payments					
Personal Health	75,989	116,255	5,363	1,018	198,625
Mental Health	13,665	2,601	0	0	16,266
Disability Support Services	161	0	0	76,198	76,359
Public Health	0	1,337	367	0	1,704
Maori Health	0	566	5,176	66	5,808
Total SOI Operating Expenditure	414,153	161,514	23,278	92,424	691,368
Surplus (Deficit)	5,277	(6,128)	1,356	(8,001)	(7,495)

Statement of Comprehensive Income

$000s

	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
DHB Provider Revenue	331,443	361,533	390,983	407,707	425,279	443,675
DHB Funder Revenue	259,196	272,492	281,457	293,672	306,417	319,716
DHB Governance & Administration	4,822	368	(0)	(0)	(0)	(0)
Inter District Flow Revenue	9,431	9,907	11,433	11,930	12,447	12,987
Total Revenue	604,892	644,300	683,873	713,308	744,144	776,378
DHB Provider Operating Expenditure	315,346	348,444	369,001	384,694	401,062	418,134
DHB Non Provider Funded Services	189,740	204,422	210,999	218,787	226,900	235,350
DHB Governance & Administration	3,872	325	383	400	417	435
Inter District Flow Expense	76,682	80,367	87,768	89,680	91,637	93,640
Total Operating Expenditure	585,639	633,559	668,151	693,561	720,016	747,560
Earnings before Interest, Depreciation, Abnormals & Capital Charge	19,252	10,742	15,722	19,747	24,128	28,819
Less						
Interest on Term Debt	643	71	502	524	547	570
Depreciation	12,767	12,993	14,496	15,125	15,781	16,466
Earnings before Abnormals & Capital Charge	5,842	(2,322)	724	4,099	7,800	11,782
Profit/(Loss) on Sale of Assets	-	-	-	-	-	-
Net Operating Surplus (Deficit)	5,842	(2,322)	724	4,099	7,800	11,782
Capital Charge	8,067	8,465	8,220	8,577	8,949	9,337
Surplus (Deficit)	**(2,225)**	**(10,787)**	**(7,495)**	**(4,478)**	(1,149)	2,445
Revaluation of Fixed Assets	0	(20,603)	0	0	0	0
Comprehensive Income	**(2,225)**	**9,816**	**(7,495)**	**(4,478)**	**(1,149)**	**2,445**

Statement of Movements in Equity

$000s

	2016-17 Audited Actual	2017-18 Forecast	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
Equity at the beginning of the period	127,311	149,762	159,618	152,123	147,644	146,495
Surplus/Deficit for the period	(2,225)	(10,787)	(7,495)	(4,478)	(1,149)	2,445
Total Recognised Revenues and Expenses	125,087	138,975	152,123	147,645	146,496	148,940
Other Movements						
Revaluation of Fixed Assets	-	20,603	-	-	-	-
Other	26	(18)	-	-	-	-
Equity introduced (Repaid)	24,650	-	-	-	-	-
Equity at end of Period	**149,763**	**159,560**	**152,123**	**147,645**	**146,496**	**148,940**

Statement of Financial Position

$000s

	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
Equity						
Crown Equity	40,355	65,005	65,005	65,005	65,005	65,005
Retained Earnings	2,390	(8,398)	(15,893)	(20,372)	(21,519)	(19,075)
Subsidiaries & unrestricted trusts	237	208	208	208	207	207
Revaluation Reserve	82,131	102,744	102,803	102,803	102,803	102,803
Capital Injections	24,650	-	-	-	-	-
Total Equity	149,763	159,560	152,123	147,645	146,496	148,940
Represented by:						
Assets						
Current Assets	41,388	30,706	23,786	19,897	20,776	26,811
Non-Current Assets	198,486	227,087	234,744	233,099	229,982	226,022
Total Assets	239,874	257,793	258,529	252,997	250,758	252,833
Liabilities						
Current Liabilities	74,765	83,301	83,463	83,068	82,485	82,485
Non-Current Liabilities	15,347	14,931	22,944	22,284	21,778	21,408
Total Liabilities	90,112	98,232	106,406	105,351	104,262	103,892
Net Assets	**149,763**	**159,560**	**152,123**	**147,645**	**146,496**	**148,941**

Statement of Cash Flows

$000s

	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
Cash Flows from Operating Activities						
Operating Income	600,256	644,966	683,423	713,083	744,032	776,324
Operating Expenditure	592,811	632,610	675,350	702,351	728,965	756,897
Net Cash from Operating Activities	7,446	12,355	8,073	10,732	15,067	19,427
Cash Flows from Investing Activities						
Interest receipts 3rd Party	2,126	841	450	225	113	56
Sale of Fixed Assets	3	22	-	-	-	-
Purchase of Fixed Assets	(11,173)	(16,996)	(21,683)	(11,480)	(10,666)	(10,508)
(Increase)/Decrease in Investments and Restricted & Trust Funds As	12,226	(1,707)	(1,773)	(2,000)	(2,000)	(2,000)
Net Cash from Investing Activities	3,182	(17,840)	(23,006)	(13,255)	(12,554)	(12,452)
Cash Flows from Financing Activities						
Equity injections (repayments)	-	-	-	-	-	-
Borrowings introduced (repaid)	181	(712)	8,248	(1,055)	(1,089)	(370)
Interest Paid	(734)	(71)	(502)	(524)	(547)	(570)
Other Non-Current Liability Movement	25	-	-	-	-	-
Net Cash from Financing Activities	(527)	(783)	7,746	(1,579)	(1,636)	(940)
Net Increase/(Decrease) in Cash held	10,101	(6,267)	(7,187)	(4,102)	878	6,035
Add opening cash balance	2,606	12,707	6,441	(746)	(4,848)	(3,970)
Closing Cash Balance	12,707	6,440	(746)	(4,848)	(3,970)	2,066

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

Key Financial Analysis and Banking Covenants

	2016-17 Actual	2017-18 Forecast	2018-19 Budget	2019-20 Budget	2020-21 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	90,112	98,232	106,406	105,351	104,262
Debt	2,487	1,775	10,024	8,969	7,880
Owners Funds	149,763	159,560	152,123	147,645	146,496
Total Assets	239,874	257,793	258,529	252,997	250,758
Owners Funds to Total Assets	62.4%	61.9%	58.8%	58.4%	58.4%
Interest Expense	643	71	502	524	547
Depreciation Expense	12,767	12,993	14,496	15,125	15,781
Surplus/(Deficit)	(2,225)	(10,787)	(7,495)	(4,478)	(1,149)
Interest Cover	17.40	32.24	14.94	21.33	27.77
Debt/Debt + Equity Ratio	2%	1%	6%	6%	5%
Banking Covenants					
Debt/Debt + Equity Ratio	1.6%	1.1%	6.2%	5.7%	5.1%
Interest Cover	17.4	32.2	14.9	21.3	27.8
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

Consolidated Statement of Financial Performance ($000s)	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
MOH Devolved Funding	568,256	605,727	645,411	673,422	702,648	733,143
MOH Non-Devolved Contracts (provider arm side contracts)	14,716	14,471	14,588	15,221	15,882	16,571
Other Government (not MoH or other DHBs)	5,840	7,184	6,425	6,704	6,995	7,299
Patient / Consumer sourced	453	637	406	423	442	461
Total Other Income	4,945	5,048	4,420	4,367	4,434	4,566
InterProvider Revenue (Other DHBs)	1,251	1,327	1,190	1,242	1,296	1,352
IDFs - All Other (excluding Mental Health)	9,431	9,907	11,433	11,930	12,447	12,987
Total Consolidated Revenue	604,892	644,300	683,873	713,308	744,144	776,378
Personnel Costs	216,991	235,137	255,574	266,665	278,239	290,314
Outsourced Services	27,857	34,736	31,975	33,363	34,811	36,321
Clinical Supplies	50,318	53,117	57,064	59,219	61,461	63,794
Infrastructure & Non-Clinical Supplies	24,052	25,781	24,772	25,847	26,968	28,139
Finance Costs	8,710	8,535	8,722	9,100	9,495	9,907
Depreciation	12,767	12,993	14,496	15,125	15,781	16,466
Personal Health	180,573	186,749	198,630	203,984	209,519	215,242
Mental Health	14,245	15,964	16,266	16,972	17,709	18,477
Disability Support Services	64,471	74,638	76,359	79,673	83,131	86,739
Public Health	1,434	1,734	1,704	1,778	1,855	1,936
Maori Health	5,699	5,704	5,808	6,060	6,323	6,597
Total Operating Expenditure	607,116	655,088	691,368	717,786	745,292	773,933
Surplus (Deficit)	**(2,225)**	**(10,787)**	**(7,495)**	**(4,478)**	**(1,149)**	**2,445**

Provider Statement of Financial Performance ($000s)	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	14,716	14,471	14,588	15,221	15,882	16,571
Other Government (not MoH or other DHBs)	5,840	6,824	6,425	6,704	6,995	7,299
Non-Government & Crown Agency Sourced	5,398	5,685	4,825	4,790	4,876	5,026
InterProvider Revenue (Other DHBs)	1,251	1,327	1,190	1,242	1,296	1,352
Internal Revenue (DHB Fund to DHB Provider)	304,238	333,227	363,954	379,750	396,231	413,427
Total Provider Revenue	331,443	361,533	390,983	407,707	425,279	443,675
Personnel Costs	215,492	235,137	255,574	266,665	278,239	290,314
Outsourced Services	27,021	34,736	31,975	33,363	34,811	36,321
Clinical Supplies	50,309	53,117	57,064	59,219	61,461	63,794
Infrastructure & Non-Clinical Supplies	22,523	25,455	24,389	25,447	26,552	27,704
Finance Costs	8,710	8,535	8,722	9,100	9,495	9,907
Depreciation	12,767	12,993	14,496	15,125	15,781	16,466
Total Operating Expenditure	336,823	369,973	392,218	408,919	426,339	444,507
Surplus (Deficit)	**(5,380)**	**(8,439)**	**(1,236)**	**(1,213)**	**(1,060)**	**(833)**

Governance Statement of Financial Performance ($000s)	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
Government & Crown Agency Sourced	4,822	368	(0)	(0)	(0)	(0)
Total Governance Revenue	4,822	368	(0)	(0)	(0)	(0)
Personnel Costs	1,498	-	-	-	-	-
Outsourced Services	836	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	1,528	325	383	399	416	435
Total Operating Expenditure	3,872	325	383	399	416	435
Surplus (Deficit)	**950**	**43**	**(383)**	**(399)**	**(417)**	**(435)**

Funder Statement of Financial Performance ($000s)	2016-17 Audited Actual	2017-18 Audited Actual	2018-19 Budget	2019-20 Budget	2020-21 Budget	2021-22 Budget
MOH Devolved Funding	568,256	605,727	645,411	673,422	702,648	733,143
Inter District Flows	9,431	9,907	11,433	11,930	12,447	12,987
Total Funder Arm Revenue	577,687	615,994	656,844	685,351	715,095	746,131
Personal Health	437,845	470,476	510,011	528,879	548,515	568,950
Mental Health	54,766	58,193	61,006	63,653	66,416	69,298
Disability Support Services	69,995	80,913	83,220	86,832	90,600	94,532
Public Health	2,203	2,504	2,345	2,446	2,552	2,663
Maori Health	5,852	5,929	6,140	6,406	6,684	6,974
Other	4,822	368	-	-	-	-
Total Operating Expenditure	575,482	618,384	662,721	688,217	714,768	742,418
Surplus (Deficit)	**2,205**	**(2,390)**	**(5,877)**	**(2,866)**	**328**	**3,712**

Signatories

Hon. Dr David Clark
Minister of Health

Sally Macauley
Chairman
Northland District Health Board

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

Dr Nick Chamberlain
Chief Executive
Northland District Health Board

Appendix B: System Level Measures Improvement Plan

Introduction

Our Improvement Plan for 2018-19 for Northland brings an increased focus on addressing key areas based on local needs to improve disparity and inequality in the health status of Māori, enhance patient experience for all and improve resources effectiveness across our geographically wide region.

As part of our district alliance's approach we have created a part time SLM coordinator role to strengthen the cohesiveness of our efforts and ensure we can demonstrate an integrated partnership approach in the ongoing cycle of development and implementation of the improvement plans. A plan to socialise the System Level Measures programme across our whole community will also be an outcome of this.

Our Health Profile

Māori

Māori experience low levels of health status across a range of health and socio-economic statistics. They comprise 34.9 percent of Northland's total population, but 52 percent of the child and youth population, a key group for achieving long-term gains. Māori experience early onset of long-term conditions like cardiovascular disease and diabetes, presenting to hospital services on average about 13 years younger than non-Māori.

Child and Youth

The child and youth proportion of Northland's population is projected to decline over the coming years from 32.7 percent in 2018 to 30.7 percent in 2028 but remains a priority because healthy children make for healthy adults and because children are more vulnerable than adults. The deprivation index, which divides New Zealanders into ten groups according to their deprivation scores, placed 80 percent of the population on the most deprived half of the index.

Older People

Our ageing population is placing significant demands on health services provided specifically for older people (residential care, home and community support services, day care). It also increases the prevalence of long-term conditions which become more common with age.

Long Term Conditions

About three-quarters of deaths in Northland are from cardiovascular disease (heart disease and stroke) or cancer (the most common sites are trachea-bronchus-lung, colorectal, prostate and breast). Twenty percent of adult Northlanders have been told they have high blood pressure and 12 percent that they have high cholesterol, both known risk factors for cardiovascular disease. While diabetes is not a major killer in itself, it is a primary cause of heart disease. A great deal of unnecessary illness and hospitalisation is related to poor management of diabetes.

Oral Health

Northland's children have long had some of the country's poorest oral health, though that has improved markedly in the last few years. Even so, only 44% of five-year-olds have no dental caries, with a marked disparity between Māori (28%) and non-Māori (63%). No water supplies in Northland are fluoridated, which detrimentally affects our oral health status.

Lifestyle Behaviours

The way people live their lives and the behaviours they exhibit have an enormous effect on health status. There are a wide range of influences, but key ones are smoking, diet, alcohol and other drugs, and lack of physical activity.

Social Influences

Many of the causes of ill health rest with social and economic factors such as housing, education and economic prosperity. The health sector cannot affect these directly, but as a district health board we work collaboratively with other Government and local body organisations to achieve a healthier Northland.

Name	Organisation	Date	Signature
Donovan Clarke	Chief Executive Manaia Health PHO		
Jensen Webber	Chief Executive Te Tai Tokerau PHO		
Dr Nick Chamberlain	Chief Executive NDHB		

Patient Experience of Care

Where are we now?

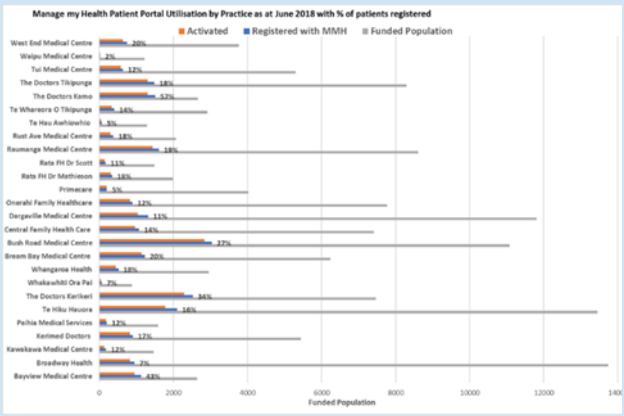
Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. Northland DHB and Northland's PHOs are working together to ensure we are gaining insight into the patient experience and implementing a Quality Improvement approach across the system with a focus on equity of health outcomes across the population of Te Tai Tokerau/ Northland.

Where are we now?

Primary Care Patient Experience Survey is planned to be active in Northland from Feb 2018 in a staged implementation.

Patient portal is available in some practices in Northland and uptake, at this stage, is optional for use within general practice. It is however strongly supported and encouraged by the PHOs.

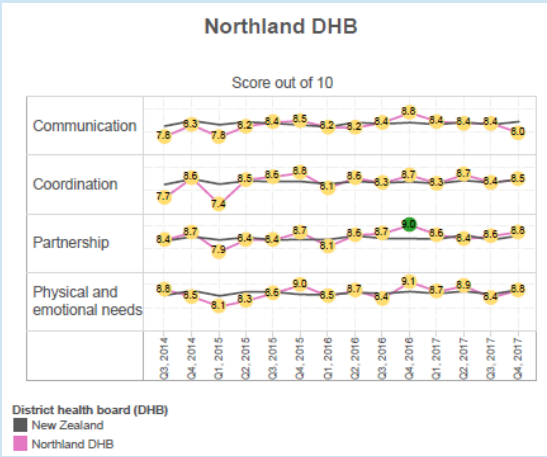
Northland PHO Patient Portal uptake June 2018



National Enrolment Service is utilised across Northland primary health care.

Inpatient survey within DHB in use as per MoH guidelines.

Northland DHB inpatient survey report Feb3 2018



How will we get there?

Milestones

Northland hospital patients will rate their overall inpatient experience at 8.5 or greater in the 4 key domains measured

100% of all Northland PHO practices will be participating in the Primary Care Patient Experience surveys by December 2018.

Contributory measures

Hospitalised patients completing an adult inpatient survey

GP practices offering and patients accessing and using patient portals

General Pctitioner (GP) practices participating in obtaining feedback from patients via the Primary Care Patient Experience Survey

Patients providing feedback via the Primary Care Patient Experience

Activity

NDHB using adult inpatient survey according to MoH guidelines.

General practices are using Primary Care Survey according to MoH guidelines.

Patients and Whānau are given a voice and are active participants in their care planning, utilising patient portals such as the Whānau Tahi tool and Manage My Health.

Equity outcomes are considered with specific professional input from NDHB Māori Health Directorate team and Primary Health Care Māori Health Lead.

Promotion of patient portals within PHC will be stongly encouraged.

Communication has been identified as a priority improvement area where several quality iniatives across the health system have been planned:

- communications framework to be implemented and refined to promote use of survey tool both within general practice and the community
- promotion of use of patient portals within PHC
- evaluation of use of patient portal and the PES

	Survey	survey results during 2018/19 to grow participation rates and address areas of concern. Development of a specific Quality Improvement Plan led by the Northland PHO/ Northland DHB Quality teams to identify further improvement opportunities/ ideas and a change management process with support to general practice, Northland DHB and PHOs.

Ambulatory Sensitive Hospitalisations ages 0-4

Where are we now?

Northland DHB and Northland PHOs believe that all tamariki; particularly tamariki Māori living in Northland, should have access to quality primary care. Broad approaches are being planned to impact across the district, with the goal of reducing inequity and improving access for tamariki who live in highly deprived communities. This plan sets out our specific actions, all with a focus on increasing access for tamariki, reducing inequities and ensuring quality primary care.

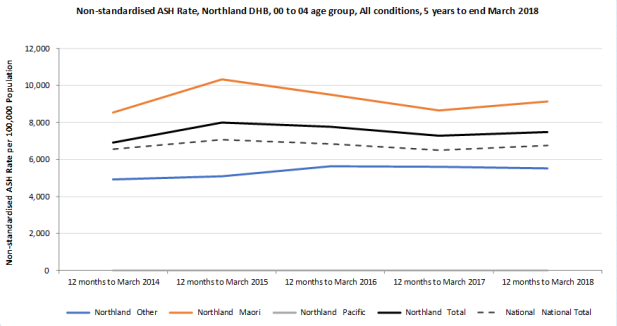
Where are we now?

The top 10 ASH conditions in Northland are dental, asthma, upper and ENT respiratory infections, pneumonia, gastroenteritis/ dehydration, cellulitis, lower respiratory infections, dermatitis and eczema, constipation, GORD.

ASH rates for tamariki in Northland are higher than the national average.

High levels of inequity for ASH events for tamariki Māori compared to non-Māori.

There are significant inequities experienced by condition between tamariki Māori and non-Māori in dental related conditions, asthma, pneumonia, dermatitis and eczema events.



How will we get there?

Milestones

Reduce the equity gap by 5% from 2,996 to 2,846 (non-standardised rate per 100,000, year to end of Dec 2017).

Contributory measures

Caries free at five years

Preschool children enrolled in publically funded child oral health service

Hospital admissions for children aged five years with dental caries as primary diagnosis

Hospital admissions for children aged five years with a primary diagnosis of asthma

Percentage of children aged 4 years and under who received seasonal influenza vaccine

Activity

Oral Health

Develop a business case, and submit for funding, for free oral health care for pregnant Māori women and women living in quintile 5 areas. Develop a staged approach to implementation, starting with hapu mama attending kaupapa Māori and mainstream education programmes.

Implement key recommendations from the oral health co-design project for pre-school enrolment targeting high needs tamariki aged 0 to 2yrs.

- expand 'Little Chompers' to include Mid North and Whangarei area
- increase preschool enrolment utilising oral health therapsists in clinics across Northland
- conduct a series of presentations across Northland health service regarding Community Water Fluoridation policy and promotion in local communities.

Respiratory

Review and improve process for sharing of acute-care management plans (including when to recommence maintenance plans) between paediatrician and GP at transition of care.

Develop criteria and commence trial of script collection prior to discharge for priority groups of children, such as those with acute respiratory conditions, toward reducing barriers to timely collection of medication.

Expand the Far North virtual MDT to Whangarei between primary care, child health services and Paediatric Outreach. Utilising ED presentation data identifying children who have presented with acute

		respiratory ASH >3 times in a 12 month period. Review and improve the process of delivering funded flu vaccines in secondary and primary care services to children who have presented with acute respiratory ASH conditions according to IMAC eligibility criteria. Socialisation of the health pathways for five respiratory conditions into primary care, with the management of acute asthma and chronic wet cough being covered in the programme of primary care CME/CNE. Scope and develop the business case for respiratory nurse specialist role in paediatrics to link with primary care Long Term Conditions and Respiratory Nurse Specialist roles.

Amenable Mortality ages 0-74 and Acute Bed Days

Where are we now?

Northland DHB and Northland's PHOs are working to provide new innovative models of integrated care that will reduce amenable mortality and acute bed days. Our approach continues to pursue a flexible, quality health system delivering the most appropriate care in the most appropriate setting.

We acknowledge that the ages affected by the two measures are different (acute bed days mainly concerns over-75s and amenable mortality mainly younger people) but by and large the causal factors are similar. For that reason, we have kept the two measures combined in this year's plan. In ABD we have put the focus not on age but on the large equity gap apparent in the data (Q5's bed day occupation is ten times that of Q1). This emphasis on equity ties in with the higher prevalence of risk factors such as smoking and poor diabetes management in deprived populations.

Where are we now?

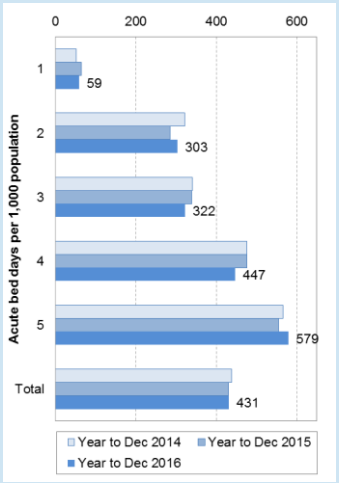
Coronary heart disease is the leading cause of amenable mortality in Northland. Tobacco consumption and diabetes are leading contributory factors to coronary heart disease. Effective identification, management and treatment of tobacco use and diabetes management is a focussed area that can provide meaningful improved patient outcomes in Northland.

We have reduced the acute bed day rates for those living in quintile 4, but there has been an increase for those living in quintile 5. In Northand, Māori are over represented living in quintiles 4 and 5, and experience tells us that tobacco use is higher in Māori compared to non-Māori, therefore a direct correlation between these two measures exists.

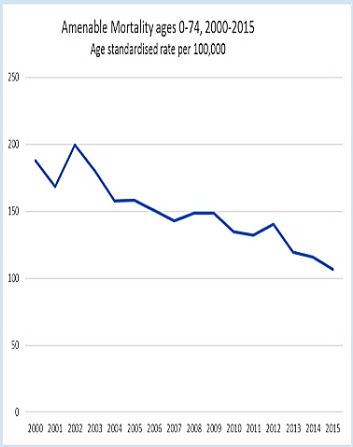
Our Primary Options Northland programme is oversubscribed and opportunity exists to implement a new model of care focussed on acute demand management.

We are supporting new models of primary care to focus resources on those most at risk and in need.

Acute bed days by quintile 2014-2016



Amenable mortality ages 0-74, 2000-2015



How will we get there?

Milestones

Reduce acute bed days for those in deprivation quintiles 4 and 5 by 3%

Reduce the amenable mortality rate for Māori by 20% by 2021

Contributory measures

Achieve 90% CVDRA rate for Māori population

Improve for Māori male age 35-44 years CVDRA rate from 62%

Multi-disciplinary shared care plans

Improve the primary care Māori rate of brief smoking advice from 83%

Activity

Devise a reporting template that would be shared with NDSAG and provide a framework for contractual reporting obligations; using data to inform our service delivery.

Utilise the work prepared by Otago University on locality mapping which shows our population demographics and identifies gaps in service provision. Use this knowledge to target resourcing.

Roll out DSME for all of Northland targeted to patients with poorly controlled HbA1c.

Increase referrals for follow on support for diabetic patients to allied services such as GRx, dieticians and whakamana hauora, develop a method to measure positive patient outcomes.

Implement a new model for an integrated acute demand service to provide resources to community

		providers to reduce hospitalisation and acute demand on secondary services. Provide guidance to general practice to continue to risk stratify their high needs population to support the optimum use of Kia Ora Vision and implement patient centred treatment packages. Continue to invest in, expand the roll out of, and provide ongoing support to practices involved in Neighbourhood Healthcare Homes. Increase number of patients with long term conditions to be offered a patient careplan (Whānau Tahi) by any provider, and any declines to be documented.

Youth Health

Where are we now?

Youth are healthy, safe and supported and the rates of chlamydia infection are reduced in Northland

Where are we now?

In the 2017 STI quarterly lab reports Northland had rates of chlamydia ranging between 165-180 per 100000 population. This is higher than the NZ average rates.

In 2014 MoH released that nationally Māori females aged 15-19 years reported the highest estimated rate of chlamydia, more than twice the national estimate.

There are significant differences in access to Chlamydia testing between males and females overall.

2015 Northland Rates of Chlamydia Testing		
Coverage (% of age group tested)		
Ethnicity	**15 to 19**	
	Male	**Female**
Māori	8.2	27.5
Pacific peoples	2.3	6.5
Asian	-	6.6
MELAA	-	-
European or Other	2.7	15.9
Unknown	-	-
Total	**6.2**	**22.8**

Where are we now?

Milestones

Sustained and incremental increase in Chlamydia testing coverage for 15–24 year olds

5% increase in Chlamydia testing coverage for all males

10% increase in Chlamydia testing coverage for Māori males

Contributory measures

Increase school based clinic screening of Chlamydia by 5-10%

School based screening of school enrolled youth is increased by 30% in males and 10% in females

Māori representation of chlamydia rates is representative of population %

Activity

Plan during Q1 and with key stakeholders; school based health services and schools, delivery of a pilot screening programme in Term One of 2019. The pilot will seek to deliver school-wide chlamydia screening in five established school-based health centre sites for Years 11-13. The purpose is to provide a benchmark of background chlamydia rates in this population of students.

Once the programme is completed and the data analysed, develop an action plan that includes delivery of a youth community awareness campaign and increases opportunities for screening/treatment in both school based health clinics, youth health hubs, general practice and community pharmacy. If appropriate actions could include expansion of the school-wide screening programme to other schools and include year 9-10 students.

Utilise Northland's youth health database to monitor rates of chlamydia diagnosis and subsequent treatment and follow-up screening before and after the pilot and implementation of the action plan.

Babies Living in Smokefree Households at 6 weeks

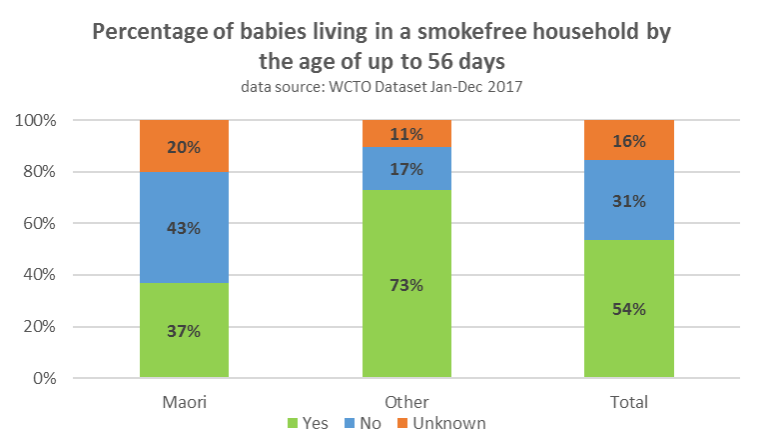
Where are we now?

All pepi and tamariki live in a smokefree environment

Where are we now?

The latest available data from the Well Child Tamariki Ora dataset tells us that we have large inequities between babies living in Māori households and non-Māori households. Just over half of Northland babies live in a smokefree household, 37% of Māori babies live in a smokefree household, 73% of non-Māori / other babies live in smokefree households.

Another concern is that the smoking status of 20% of Māori households is not recorded, compared with only 11% of other households. This large gap in data collection will be the focus in the next six months.



How will we get there?

Milestones

Increase the % of Māori babies living in a smokefree household at six weeks to 50%

Contributory measures

Pregnant women who idenity as smokers upon registration with a NDHB employed midwife or LMC who are offered brief advice and support to stop smoking.

Babies whose family/ Whānau are referred from a LMC to a Well Child/ Tamariki Ora provider

Four year old children living in a smokefree home (B4SC)

PHO enrolled patients who smoke have been offered help to quit smoking by a health care professional in the past 15 months.

Hosptial patients who smoke and

Activity

Bi-monthly training delivered to Well Child Tamariki Ora providers to collect consistent smoking information to improve data quality and reduce the percentage of unknowns in households.

Provide hapu mama stop smoking incentives to pregnant mothers participating on Hine Kōpū (Kaupapa Māori Antenatal Programme).

Expand the stop smoking incentives programmes to include Māori Whānau with infants under 1 year of age

Launch the Toki Rau Stop Smoking website and fund a health promotion campaign for smokefree Whānau with incentives.

Utilising PDSA, implement Northland PHOs quality improvement plan in prioritised GP practices to increase better help for smokers to quit target

“Effective Stop Smoking Conversations with Pregnant Women” online training to be rolled out to GP practices, LMCs and midwives over next 12 months

	are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	

Appendix C: Table of Northland DHB priorities

From the presentation to the 26 June meeting with MoH

Equity and Primary Health Care	Mental Health	Child Health & Wellbeing	System and Stewardship
• Neighbourhood Healthcare Homes • Collaboration Kaupapa • Acute Demand Management • Māori Health Service Review • Telehealth & Mobility	• Cross-sector and community collaboration • Te Ara Oranga • Employment Placement Programme • He Tipua Oranga – Pregnancy & Parenting Service • Drive Soba Programme • Social Wellbeing – intersectoral activity	• SUDI Prevention • Maternal and infant care coordination • Kaupapa Māori antenatal education • Early engagement of Māori pregnant women with LMC • Reduction in DNA to child health services • Expansion of Kaiāwhina service	• Whangarei Hospital Site Master Plan • Workforce Development • Health Intelligence • Innovation, Improvement & Excellence • Staff Wellbeing and Culture