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

ANNUAL PLAN 2021/22

incorporating

STATEMENT OF PERFORMANCE EXPECTATIONS 2021/22

Presented to the House of Representatives

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

Hon Andrew Little

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

Harry Burkhardt
Chair
Northland District Health Board
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Tēnā koe Harry

Northland District Health Board 2021/22 Annual Plan

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

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

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

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

More broadly, we also confirm the importance of your Board delivering on the Plan in a fiscally prudent way and we have asked the Ministry of Health (the Ministry) to ensure the delivery of agreed equity projects is closely monitored.

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

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry, including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

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

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

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Nick Chamberlain
Chief Executive of Northland DHB

Contents

1 Overview of Strategic Priorities

1.1 Strategic Intentions, Priorities, Outcomes

Vision and mission

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

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

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

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

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

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

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

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

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

Strategic priorities

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

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

So far we have completed an extensive engagement process that has involved online feedback, community hui and clinical hui, and have prepared a draft summary of what we were told. We are currently drafting the strategy document and hope to have it launched by the end of June.

Immediate Priorities

Our priorities for the next twelve months remain focused on equity and accessibility and include increased investment into Māori Health, Planned Care, Diabetes and our vulnerable services. We

are also focused on shifting more services from hospital to community services, enabling our non SMO workforce, kaiāwhina, working at a top of scope strategy, and building on the positive service developments and virtual care models that emerged during the COVID-19 response.

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

Kotui Hauora

Kōtui Hauora is the Iwi Māori Partnership Board across the Northland, Waitematā and Auckland DHBs. The Kōtui Hauora Board is made up of three Iwi representatives nominated by Te Kahu o Taonui from Te Aupōuri, Ngātiwai and Ngāi Takoto, the three DHB Board Chairs and one independent chair.

Kōtui Hauora has continued to make incremental progress over the last twelve months towards achieving its purpose to become a co-commissioner in partnership with Northland, Waitematā and Auckland DHBs.

- delivery of the COVID-19 vaccination programme
- informing and influencing the implementation of the HDSR
- ongoing implementation of the Maori health pipeline programme

Kōtui Hauora successfully secured $13m from the MOH to support delivery of the COVID-19 vaccination programme for Māori. This funding covers a range of activities including:

Kōtui Hauora has also successfully secured $1.2m of infrastructure funding from DHB CEs to enable it to co-commission the Covid-19 vaccination services for Māori. While delivering this programme of work, Kōtui Hauora will use the key learning to inform the design and development of the HDSR changes. For example, Kōtui Hauora has developed a “commissioning for outcomes” approach for the Covid-19 vaccination programme based on the needs of the various localities across Kōtui Hauora. This will inform our future commissioning approach under the new system.

Working with iwi, hapū, whānau and Māori communities

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

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

Ensuring out-year planning is robust and supports system sustainability

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

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

Annual planning

Since the passing of the Public Health and Disability Act 2000, Northland DHB has produced an Annual Plan to meet the requirements of S38(1)(a).

Commitments

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

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

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

Northland DHB is also committed to Whakamaua Māori Health Action Plan 2020-2025 that provides a roadmap of tangible actions that contribute to achieving the vision of pae ora for Māori.

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

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

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

Northland DHB is committed to the principles of Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan, namely:

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

Northland DHB is committed to supporting the rollout of the Covid-19 vaccination programme.

Iwi partnership board

Northland DHB is a partner in the Northern DHB partnership board, Kotui Hauora. Kotui has an established workplan and delegated authority from Northland, Waitemata and Auckland DHBs to provide oversight at a governance level of Māori health funding. In particular it is overseeing Covid-19 and Covid-19 vaccination funding for Māori, as well as a pipeline of research initiatives such as aortic aneurysm screening and lung cancer screening for Māori. It does not cosign or provide oversight for our Annual Plans.

1.2 Message from the Chair and Chief Executive

This is our final Annual Plan. The health reforms will usher in the formation of Health NZ from 1 July 2022. After twenty years, Northland DHB and most of the health sector are ready for change that aims for an even stronger acknowledgement of our Te Tiriti obligations and equitable health outcomes. We all want to see a more coherent and nationally consistent system that enables its many parts to work together more effectively and harmoniously. We look forward to a NZ Health Plan that makes strategic national priorities clear to everyone and sets out guidelines within which locally tailored primary and community services can be adapted and developed. We think the new system will be transformative enough to create the opportunities to which Iwi/ hapu/ Māori aspire around wellbeing. We endorse the willingness to raise the view so it encompasses the community as well as the health system. We support the intention to develop multi-year plans that entail higher-level reporting and monitoring, and the desire to move away from the current shorter term, operational focus. Separate appropriations for our Hospitals and Primary and Community should see a move towards an investment approach that truly reverses the inequity of under-investments of the past. Above all, we believe a transformative approach is a prerequisite to achieving equity in health.

We will be working closely with the Ministry of Health, the Transition Unit and interim Health NZ to help with design of the multiple parts, provide required information, identify and mitigate risks, particularly to our workforce – both their wellbeing and retention – and we want to ensure that the changes are as smooth and painless as possible. We will also work hard to ensure that a national health system does not lose the voice of Northland. Kotui Hauora, our Northern Region Iwi-DHB partnership board, is our Te Tiriti partnership with Te Kahu o Taonui.

Our community and health sector recognition of the need for transformation is reflected in our health Strategy, which is just being finalised for approval from our Board. The Strategy has been derived from the voice of our community and health workforce, and the inclusive engagement process has generated unified commitment from all parties. The Strategy takes a high-altitude view that identifies the fundamental changes needed, but there is a lot more work yet to be done with the health sector and the community to make it a practical reality. It is not a solution but a solid first step that, because it aligns neatly with the national health and disability reforms, provides a solid foundation for our future.

The need for change is particularly acute. In Northland we have many strengths including our population having a very high percentage of Māori, sustained rapid growth (partly due to immigration from Auckland), and we are older than most other districts (4.6% more over-65s than the national average). However all these strengths do place significant demand on our health services. We are also challenged by our significant rurality and poverty.

Our greatest challenge and our highest priority is the relentless pursuit of equity; Northland DHB is committed to ensuring equity of access, experience and outcomes among those populations that need our support the most. The ongoing effects of colonisation and racism that have discriminated against Māori continue to be reflected in health inequities.

Particularly exciting in the new environment are the opportunities available to develop more robust, responsive and effective primary and community services. Te Tai Tokerau will be able to build on existing projects initiated under Northland DHB, including Neighbourhood Healthcare Homes, the Calderdale framework, Whānau Tāhi's single patient record, and we also plan to invest significantly in General Practice and Maori Provider workforce development. We have learnt from some of the initial work we have done with Mahitahi Hauora around locality development and look forward to being heavily involved in phase two which will be more focused on community needs and aspirations.

Northland DHB continues to build capacity and capability in our services. Investments in Whangarei Hospital's capability alongside our satellite Hospitals in Kaitaia, Kawakawa, Hokianga and Dargaville are part of our drive to bring services closer to our communities. In recent times we have established a new Assessment Unit for acutely ill patients, two new theatres and patriated the cardiac catheterisation service from Auckland. We are currently working on moving child health services and the Laboratory to the second floor of Te Kotuku (the maternity building). We are also developing Stage 2 of Bay of Islands Hospital (which will include primary care, community services, outpatients, renal and some cancer services) and completing the site master plan for Kaitaia

Hospital. Northland DHB has submitted a detailed business case for the Whangarei Hospital redevelopment to the July meeting of the Ministry of Health's Capital Investment Committee and we will have completed the detailed design, stakeholder and market engagement by the end of the year. Our workforce is the health system's greatest asset and Northland DHB continues to develop new ways of supporting them so they can fulfil their passion to serve their community.

The Annual Plan is closely aligned with the Northern Region Long Term Health Plan (an evolution of the Northern Region Long Term Investment Plan) and its Triple Aim of population health, patient experience, and value and sustainability. 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. Relevant regional performance measures have been integrated into the Annual Plan.

As we approach our final year of existence, Northland DHB remains committed to the Government's aim of delivering better public services within tight financial constraints, protecting our population from COVID-19 while continuing to successfully roll out the COVID-19 vaccination programme. We look forward to the opportunities presented by the future health system and will ensure that the Northland health sector is ready to seize them .

1.3 Signature page

Hon. Andrew Little
Minister of Health

Hon. Grant Robertson
Minister of Finance

Harry Burkhardt
Chair
Northland District Health Board

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

Dr Nick Chamberlain
Chief Executive
Northland District Health Board

2 Delivering on Priorities

2.1 He Korowai Oranga

These linkages apply to all priorities under 2.1	***Government theme:*** Improving the wellbeing of New Zealanders and their families	
	System outcomes	***Government priority outcomes***
	We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child

2.1.1 Engagement and obligations as a Treaty partner

DHB activity	Milestone	Measure
1a Support the development and implementation of the Northern Region's Health Equity Plan. 1b Work with Kōtui Hauora (the Northern Iwi-DHB Partnership Board) to implement the actions from their work plan. The work plan for Kōtui Hauora includes aligned DHB and iwi priorities for Māori health development and gain. These actions will require resourcing by the DHB to be completed.	June 2022: • NDHB specific actions implemented • Kotui Hauora work plan implemented.	
2 Design and deliver training to DHB Board members and Kōtui Hauora members to improve their understanding of the system, and to identify where opportunities exist. Training to include: • Treaty of Waitangi • Racism and bias within the health system • Māori health inequities • Mātauranga Māori. The training offered will have relevance to ensuring the environment and the systems that are within a DHB are in context to:	June 2022: Training for NDH Board and Kotui Hauora members.	

DHB activity	Milestone	Measure
• Iwi and the local Māori health sector (strategies, workforce and providers) • local and regional and national health system …to address: • systemic racism • issues and opportunities within the Health system • priority health and social issues for Māori.		

2.1.2 Whakamaua: Māori Health Action Plan 2020-2025

DHB activity	Milestone	Measure
Workforce (*Whakamaua action 3.1)* 1.1 Activate the Kia Ora Hauora Connect Portal and make it accessible to new graduates and hiring managers within the DHB. 1.2 Formalise a partnership with MSD to implement cadetships with Māori clients for entry into the health sector.	Q2: KOH Portal activated and accessible to stakeholders. Q4: Cadetships formalised and implemented.	
Workforce (Whakamaua action 3.3) 2 Continue to progress Northland DHB's Affirmative Action Plan which addresses attracting, retaining, developing and utilising our Māori health workforce effectively, including in leadership and management.	Report in Q2, Q4.	
Kaupapa Māori primary mental health and addiction services (*Whakamaua action 4.4)* 3 Continue with Te Tumu Waiora program funded packages of care for decile 5, Māori and Pasifika registered with general practices, including health improvement practitioners and health coaches.		% Māori clients (38% in Feb 2021).
Innovative technologies and telehealth (*Whakamaua action 6.1)* 4 See action 3 in 2.6.12 Data and digital enablement.		
Tobacco control, immunisation and screening programmes (*Whakamaua action 4.7)*	Q2: Investment in Māori health providers for screening services is in contract for service.	

DHB activity	Milestone	Measure
5.1 Maori health providers are invested in to deliver Stop Smoking Services, Influenza, Measles and Covid-19 Immunisation programmes to ensure Māori whānau are prioritised in accessing these services. 5.2 Māori providers will be an integral part of promoting and supporting the Bowel Screening Programme beginning in Aug 2021.	Q4: Māori health providers are brought in early in the planning and development of the Bowel Screening Programme.	
Equitable health outcomes for Māori (*Whakamaua action 8.2)* 6.1 Kōtui Hauora is NDHB's Tiriti based partnership with our iwi partners. It is through this mechanism that plans across the northern DHBs will be discussed in depth with iwi. Local plans will follow existing local iwi/ Māori partnership engagement processes. 6.2 In the coming year, we will work with Kōtui Hauora to understand their priorities for the next one to five years, and start development of a work plan and allocate necessary resources to achieve tasks linked to their priorities. 6.3 Engage with iwi to understand their health and wellbeing priorities. 6.4 Develop a work plan to capture these priorities and agreed associated actions. 6.5 Agree and allocate resources to complete these actions.	June 2022: local plans implemented.	
Engaging with local Iwi about major capital projects (Whakamaua action 1.4) 7 Continue engaging with Iwi on the proposed redevelopment of Whangarei Hospital, which aims to replace a large section of the main block and add capacity. The project is currently at the detailed business case stage. Our architects have met with the head of Northland DHB's Māori Directorate and have developed a cultural engagement plan for the project through to construction. To start this process, we organised a meeting with Iwi representatives from across the region. This had to be	2021/22: gain funding approval. Once that is achieved, a more detailed programme with specific engagement activities at each stage in the project process will be confirmed, leading to design work in 2024 and completion of construction by 2027.	

DHB activity	Milestone	Measure
postponed due to Covid-19 restrictions but will be rescheduled.		
Growing the capacity of iwi and the Māori health sector as a connected network of providers to deliver whānau-centred and kaupapa Māori services (*Whakamaua action 4.9)* 8 We are committed to supporting the Māori health sector to provide integrated and whānau-centred care that is accountable to the communities they serve. We need to ensure they are agile enough to respond to needs, and funded to achieve outcomes. The Oranga Māori Entity proposal that has responded to the Health and Disability System Review report and WAI 2575 Report to Ministry of Health may have an impact on future continuity with the DHB. Invest in two Māori providers that have agreed to integrated Commissioning for Outcomes contracts. This includes: 8.1 Ensure all Te Hiku Hauora and Te Ha Oranga Māori health providers have integrated contracts to allow for holistic models of care. 8.2 Work with Māori health providers to reorient services to be better aligned with the needs in their community. 8.3 Implement a sustainability process with Māori health providers.	Q2: monitor progress towards Commissioning for Outcomes contracts. Q4: Commissioning for Outcomes Contracts are in place by 1 July 2022.	
Delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan (Whakamaua action5.6) 9.1 See 2.6.3 Health outcomes for disabled people. 9.2 Work across the Northern Region to review the value of existing services to tāngata whaikaha and their whānau.	By June 2022, look at children's disability health services provided by DHBs to understand how responsive their model of care is to their patients and their whānau. This will include: • refining data being recorded and reported by disability services for equity • linkages with Māori health and whānau ora providers • co-designing of new or enhanced services if necessary.	
Major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori. (*Whakamaua action 8.5)* 10 Kōtui Hauora has the potential to provide oversight and guidance for major funding decisions within the northern-	By June 2022: • prioritised funding identified, allocated and aligned to Iwi and DHB priorities • equity targets established and aligned to priorities • activity is monitored against performance targets.	

DHB activity	Milestone	Measure
most DHBs. This requires some critical pieces of work to occur: • identify shared iwi and DHB priorities to focus resource and attention • establish equity focused targets aligned to these priorities • provide actions for each of these targets • allocate resources to achieving these targets.		

2.2 Improving sustainability

These linkages apply to all priorities under 2.2	***Government theme:*** Improving the wellbeing of New Zealanders and their families	
	System outcomes	***Government priority outcomes***
	We have improved quality of life	Support healthier, safer and more connected communities

2.2.1 Short-term focus – 2021/22

DHB activity	Milestone	Measure
1 Implement a programme of initiatives in conjunction with the PHE to support and develop the primary care and Māori health provider workforce, including focus in 2021/22 on: • expansion of the Healthcare Home programme and implementation of a fourth tranche of practices • development of a shared service function to provide recruitment support to general practice • development of a Northland Science Academy within earmarked schools • additional support to scale up MDT case reviews between general practice and secondary specialists.	Q1 workplan in place. Q4 post-implementation review on projects.	These actions approach sustainability from a systemic point of view. Instead of short-term efficiencies or financial benefits within our own organisation, Northland DHB wants to support the sustainability of Northland's primary and community services. If these are better resourced and supported they will be healthier and more stable, and Northland DHB will experience fewer downstream effects on its services. The health system will work better because Interventions upstream will reduce effects downstream, thus enhancing the overall sustainability of the health system in Northland.
2 *Enhanced investment into Tier 1 workforce initiatives.* Northland DHB is committed to significant additional investment into primary care over the coming 12 months to support and sustain our primary care workforce across General Practice, Māori Providers and other NGOs working in the Tier 1 environment. These include dedicated investment into new models of care, a wider workforce blend, GP pipeline initiatives, a health science academy, further after-hours support, GP recruitment bureau and further investment to expedite the development of a comprehensive shared care patient management system. *[Copied from 2.7.1 Primary care action 1.].*	Q1: Implementation plans approved and funding allocated for at least two of the above themed initiatives. Q4: Four new funded initiatives under way, as well as a clear longer term strategy for encouraging more of today's students across secondary and tertiary education into science based disciplines. These will grow our workforce to reflect the population and ensure we have appropriately skilled staff ready to fill roles vacated by the ballooning retiring worker generation.	

DHB activity	Milestone	Measure
3 *Reduce hospital based interactions.* Continue investment into primary and community initiatives that enable patients, particularly Māori, to receive timely access to care, with an improved patient experience and with interventions that continue to reduce hospital based interactions. *[Copied from 2.7.1 Primary care action 2.]*	Q2: Whangarei community hub to be in a fully operational state, with experiences and outcomes from this prototype feeding into further expansion of the concept into our rural hospital hubs. Q4: Significantly greater proportion of interventions happening in the community. This population measure must have an equity focus and services must be tailored to ensure avoidable hospital admissions/ episodes for Māori are on track to drop to below 35% of all hospital admissions/ episodes.	
4 Northland DHB has developed a comprehensive production planning model in conjunction with Ernst and Young. The intention has been to use this in 2021/22 to support the scheduling of surgical volumes by department and to monitor progress to agreed monthly volume targets with the Ministry of Health.		It is not possible to anticipate definitive volumes. Experience during 2021/22 showed us that the combined impacts of Covid-19 and the mandated local and regional response to Planned Care saw Planned Care revenue 6% less than contracted and expected revenue, and Planned Care Improvement Action Plan revenue was 47% less than contracted and expected revenue. 33% of nationally available Planned Care improvement action plan revenue was not paid, with the majority of DHBs achieving less than 50% of their expected planned care improvement projections. During July to September this year, Northland DHB delivered 95% of the agreed Planned Care volumes. In the short term, Northland DHB is undertaking this action to support service sustainability and does not anticipate financial benefits during 2021/22. We will monitor progress closely during the year.

2.2.2 Medium term focus – three years

DHB activity	Milestone	Measure
1 Implement a programme of initiatives in conjunction with the PHE to support and develop the primary care and Māori health provider workforce including focus over the next three years on: • investigate the establishment of a rural interdisciplinary Leaning Centre (rural hub) • advocacy for broader admission concessions to medical school • support for practices to obtain teaching accreditation.		*See under short-term actions 1, 2 and 3.*
2 2.6.12 Data and digital enablement action 3 which describes expansion of Telehealth.		The next stage of the strategic adoption of Telehealth in Northland DHB is for a Telehealth Outpatients Business Case to be developed which will include before-and-after indicators such as: • number of appointments at the hospital • number of appointments not attended • total distance travelled across all patients • average time travelling to and fro • total amount spent on fuel • amount of carbon emissions.
3 *Path to Breakeven.* The Financial Sustainability plan for out-years is committed to delivering savings within each year. Three significant actions include:		
3a *National initiatives.* We continue to actively engage with NZ Health Partnerships, MBIE & PHARMAC to maximise procurement opportunities for Northland. During 2021/22 it is expected that Northland DHB will have implemented the recommended Health System Catalogue solution and be utilising this to maximise procurement opportunities.	Q2: Northland DHB is engaging with and planning for the implementation of the National Catalogue. Q4: The recommended solution of the Health System Catalogue (HSC) has been implemented at Northland DHB.	When Northland DHB implements Finance, Procurement and Information Management in Feb 2022 we will be able to draw on data from the HSC. It will not be until 2022/23 that financial benefits should become apparent, so in the short term we will continue with the products we currently have.
3b *Regional initiatives.* Together with the three Auckland DHBs, Northland runs two shared service agencies, healthAlliance & HealthSource for the delivery of information technology, finance, procurement & supply chain activity. Health Source leads a Procurement Savings programme on behalf of the region. Expected savings range per annum is $1.5 to $2m	Q2, Q4: HealthSource Procurement Savings programme delivering to plan.	Latest (Oct 2021) HealthSource forecast is that in 2021/22Northland DHB will save $1.51M, comprising OPEX $0.81M and CAPEX $0.7M.

DHB activity	Milestone	Measure
3c *Local initiatives.* Various productivity & cost savings initiatives which include providing hospital services closer to home, releasing time to care, productivity & equipment & fleet management.	Q2, Q4: local savings programme delivering to plan.	Expected savings range per annum is $4M to $5M.

2.3 Improving child wellbeing

These linkages apply to all priorities under 2.3	***Government theme:*** Improving the wellbeing of New Zealanders and their families	
	System outcomes	***Government priority outcomes***
	We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child

2.3.1 Maternity care

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

DHB activity	Milestone	Measure
1 Identify and address issues of inequity within the Northland birthing population.		
1.1 Work towards establishing readily available access to data regarding maternity outcomes for Māori.		Data available on maternity dashboard and reported monthly at M&M meetings.
1.2 Ensure uninterrupted specialist obstetrician antenatal clinics at rural hospital primary units, irrespective of a Covid-19 resurgence and the summer holiday period.	Use of virtual clinics only if available workforce prevents in-person clinics.	
1.3 Review the structure and membership of the Maternity Clinical Governance Committee.		50% Maori membership. Consumer membership to include each area of four areas in Northland.
1.4 Improve services available to pregnant women with diabetes.	Establish a Diabetes Midwife Specialist role in the Mid North.	
1.5 Enhance cultural competence education.	Provide education under the umbrella of Te Tatai Ihorangi to: • Maternity Clinical Governance Committee • Midwifery leadership team.	
1.6 Increase and maintain the Māori midwifery workforce.	Update the understanding of careers advisors working in Northland schools of midwifery education programmes. Promote midwifery as a career to senior students in a further three Northland secondary schools. Implement formal collaboration with Te Kaahu Wāhine.	

DHB activity	Milestone	Measure
1.7 Develop ultrasound services for women in rural areas.	Continue work with DHB radiology services to utilise mobile ultrasound capacity. Q1 establishment of an ultrasound service in Dargaville. Provision of an uninterrupted ultrasound service at current locations.	
2 Respond to Northland's higher perinatal mortality rate.	Review all stillbirths over the past five years. Identify contributory factors and determine preventability. Q1 establish review committee: determine case inclusion criteria, methodology and review tool. Completion of data collection and review of individual clinical records. Q2 MDT review of each case with input of LMC carried out over a series of face-to-face meetings. Contributory factors and preventability identified for each case. Q3 completion of Perinatal Mortality Review report.	
3 Further develop integration of maternity with other services which contribute to maternity outcomes.		
3.1 Ensure connection of women and whānau with higher social needs to appropriate wider health services.	Midwifery participation in Te Mahuri (ongoing throughout the year).	
3.2 Maintain regular Māori midwifery input into Hapū Wananga antenatal education with a renewed focus on breastfeeding in order to address declining rates.	Lactation consultants collaborate with those midwives participating in wananga to address key messaging and updated evidence.	increase rates of Maori women exclusive breastfeeding on discharge from hospital. Increase rates of breastfeeding at 2 weeks and 6 months (ongoing throughout the year).
3.3 Improve communication between midwives and WCTO providers.	Midwife membership of the regional WCTO group (current and ongoing). Annual meetings of WCTO providers with midwives at locations centred around each birthing facility in Northland: Q1 Bay of Islands, Q2 Kaitaia, Q3 Dargaville.	
4 Implement further initiatives to support a sustainable midwifery workforce.		
4.1 Enable new graduate midwives to be employed in the DHB.	Employ new graduates in addition to current FTE allocation. Q3 at least one new graduate to be employed supported by full orientation programme; participation in MFYP; supported by Te Kahu Wahine if a Māori midwife.	

DHB activity	Milestone	Measure
4.2 Implement safe staffing standards.	Ongoing training in the use of Trendcare to capture workload data Midwife participation in DHB CCDM governance. (Ongoing throughout year.)	
4.3 Address workforce shortages in identified areas within Northland.	Update the Voluntary Bonding Scheme / MoH of acute staffing shortages in Kaitaia. Actively advertise opportunities for LMC vacancies in Kaitaia via professional organisation and social media.	

2.3.2 Immunisation

DHB activity	Milestone	Measure
Northland DHB context Ngā Tātai Ihorangi is now agreed as the framework for universal child health service delivery for whānau Māori with our partners in maternal and child health. Provider education and resources developed continue to support this approach to delivery. All immunisation messaging and media collateral continues to be framed in Ngā Tātai Ihorangi with a wellness whānau strengths-based approach. The use of social media as a strategy for connection during the 2020 lockdown is further developed with a plan to enable flexibility in approaches dependent on alert level and community identified needs. Messaging for whānau about continuity of primary care services during Covid-19 alert levels is reviewed and improved to ensure clarity and continuity of immunisation and well child screening/checks. Media collateral is also reviewed and where needed is developed utilising the agreed framework of Ngā Tātai. Working in partnership with universal child health service providers review and strengthen approaches to service delivery during changing Covid-19 levels. Northland DHB continues to grow capacity within general practice, Outreach Immunisation Services (OIS) and Plunket to confidently engage with whānau Māori about immunisation utilising the Ngā Tātai Ihorangi tool-kit as the guiding document.		
1 Covid-19 levels preparedness reviewed with each provider. Collective approach to strengthening the sector.	Q1: strengths based assessments for Covid-19 preparedness for key providers identified and completed.	
2 Regular schedule of training sessions for all providers in Ngā Tātai Ihorangi – socialising the approach and the language of strength-based service delivery with whānau.	Q2: training schedules and supportive actions agreed and first actions delivered.	
3 Review of current collateral and prioritised approach to media development.	Q2: enhanced cultural and whānau-first media engagement developed and deployed.	
4 Build the capacity for Māori health providers to lead, guide service delivery improvement and deliver immunisation to whānau Māori. This includes increasing the immunisation workforce, working collectively within the WCTO clinical forum in service improvement and	Q1: plan for action that strengthens capacity for Māori providers to deliver immunisation. 1 Work with Māori health service providers to enable provision of the well child immunisation schedule at their Covid-19 vaccination	1 Number of Covid-19 vaccinators in Māori health providers who become non-medical authorised vaccinators. Q3 2 Funding model for well-child immunisations delivered at Covid-19 vaccination clinics that is

DHB activity	Milestone	Measure
expansion of kaupapa Māori models of delivery, access to workforce development.	clinics. This requires vaccinators to be upskilled in delivery of well-child immunisations. Q2-Q3 2 A mid-north provider will prototype this model so that we can quantify any additional resources needed to implement a sustainable service across Northland post-Covid vaccination. Q2 3 It is our collective intention as immunisation partners to support the providers' capacity to continue to deliver well child immunisation as a component of their model of service delivery in tamariki ora ongoing. Q3-Q4	agreeable to both the DHB funder and partner NGOs. Q2 3 Community champions identified by each Māori health provider to support the dissemination of Ngā Tātai Ihorangi immunisation messaging to whānau attending Covid-19 vaccination centres.
5 Working with partners in Māori health and general practice, develop a collective plan for delivery of Flu-vax and MMR that aligns with delivery of the Covid-19 vaccination programme.	Agree the approach and develop an implementation plan for delivery of Fluvax and MMR to whānau Māori and other priority groups that aligns with the Covid-19 vaccination programme delivery and ensures vulnerable groups have equitable access to all immunisations available. Plans established and in place by Q2 2021/22.	
6 NDHB will continue to deliver Immunisation Outreach Services during the period of Covid-19 by concentrating on Outreach services over all of Northland and emphasising to our General Practices how important is it to maintain Well Child schedule vaccinations.	1 The incentive coverage payment with general practices vaccinating for Covid-19 to their enrolled priority populations includes the criteria of achieving well child immunisation coverage of 85% at 8 months. Both coverage targets must be achieved in order to reach the threshold for the Covid-19 incentive payment. Q3 2 NDHB in partnership with our providers, will establish regular drop-in outreach clinics across Northland for well child immunisations. These will be advertised through our social media, tamariki ora providers and champions network. Q3	1 Practice enrolled well child immunisation coverage is also discussed during NDHB Covid team site meetings, with practices participating in Covid-19 vaccinations and individual practice progress toward achieving 85% target for well child immunisations identified and shared with the practice. 2 Monitoring of immunisation coverage for to identify key areas where vaccination rates are lower for tamariki Māori.
7 Improve immunisation coverage rates for tamariki less than 2 years old.	1 The incentive coverage payment with general practices vaccinating for Covid-19 to their enrolled priority populations includes the criteria of achieving well child immunisation coverage of 85% at 8 months. Both coverage targets must be achieved in order to reach the threshold for the Covid-19 incentive payment. Q3 2 Using Te Māhuri care connection forum, immunisation data and practice level data, identify General Practices where timely enrolment of tamariki and vaccination coverage for tamariki are ongoing challenges. Working with the PHE and the identified practices select three practices to work with one-to-one toward developing an improvement plan, with specific time-framed actions. Q3	1 Practice enrolled well child immunisation coverage is also discussed during NDHB Covid team site meetings, with practices participating in Covid-19 vaccinations and individual practice progress toward achieving 85% target for well-child immunisations identified and shared with the Practice 2 PHE practice level data for vaccination coverage. 3 NCHIP milestone data, Immunisation Outreach and Te Māhuri care connection forum case discussion to identify tamariki at 3 months old with

DHB activity	Milestone	Measure
	3 Select three further practices to work with one-to-one toward developing an improvement plan, with specific time-framed actions. Q4	issues regarding GP enrolment, WCTO engagement and immunisation.

2.3.3 Youth health and wellbeing

DHB activity	Milestone	Measure
Northland DHB Context Northland DHB has a history of prioritising child and youth wellbeing. Our plan focuses on the need to understand the impact that Covid-19 has had on youth mental health and wellbeing with a view to developing action based plans focused on equity outcomes for rangatahi Māori. We will work collaboratively with key stakeholders delivering youth mental health and A&D services, to strengthen capacity of other providers of youth-focussed services (high schools/kura, community based youth health services, social services and justice) to engage with youth, recognise and assess anxiety and depression, provide simple interventions, link in with programmes/networks that strengthen resiliency of rangatahi and appropriate referral to specialist assessment when needed. We will employ a collective response approach including engagement with rangatahi Māori, to review the current pathways for assessment and referral and access using appreciative enquiry. Identify areas for improvement and opportunities for growth that can be achieved within current resource/service allocation, especially the expansion of kaupapa Māori approaches in strengthening wellbeing and connection.		
1 Working in partnership with Te Roopu Kimiora, schedule a programme of workforce education and upskilling for nurses and kaimahi working with rangatahi in assessment and primary intervention of anxiety and depression.	Q2: stocktake completed of current services delivery and programmes/networks that strengthen youth resiliency and those focussed on youth assessment/intervention for anxiety and depression.	
2 Look for opportunities to improve, resource and strengthen the access pathway for Northland youth to the full range of mental health services and programmes; inclusive of the continuum from wellbeing and resiliency programmes and networks to specialist youth mental services.	Q3: develop a train the trainer approach to delivery to enable continuity of education with the first sessions delivered.	
3 Continue to use telehealth options, including telephone consultations, face time (Zoom) consultations and delivery of prescriptions as required to young persons.	Q1-Q4.	

2.3.4 Family violence and sexual violence

DHB activity	Milestone	Measure
Northland DHB context Equity within family violence programmes is a key focus for tai Tokerau. Ngā Wānanga o Hine Kopu and Whaia te Ora wananga create safe spaces for whānau discussion about domestic violence, mental health and addiction within the context of hauora. Northland has an established Violence Intervention Programme. The next stage of development is to incorporate key messages of the Violence Intervention Programme and screening process into Ngā Tātai Ihorangi framework with whakatauki and approaches that resonate for whānau Māori.		
1 Establish stakeholder work groups, inclusive of whānau and contributing providers.	Q2: key messages identified. Whakatauki and delivery approaches agreed.	
2 Strategies for strengthening whānau and supporting access to services are facilitated. Kaupapa Māori models are utilised to frame the discussions.	Pilot programme within mini wananga and test efficacy of approach with group. PDSA process by Q1 2021/22.	

2.3.5 Ambulatory sensitive hospitalisations for children aged 0-4 (SLM)

In the ASH for 0-4 year olds section of Appendix 2 System Level Measures Improvement Plan 2020/21, the two actions that are expected to have the most significant impact on performance improvement are:

Implement a Start Well (Oral Health) pilot project initially in Mahitahi Hauora Mid-North Locality One *, to map dental service registration through to enrolment *(first bullet under the second action)*.

Northland Tamariki will be enrolled under the Koira 4Rukahukahu: Lungs4Life programme *(third action)*

2.4 Improving mental wellbeing

These linkages above apply to all priorities under 2.4

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

DHB activity	Milestone	Measure
Psychosocial response to and recovery from COVID-19.		
1 *Wellbeing Hub Hauora Kotahitanga.* Te Tai Tokerau directory of wellbeing services and resources will include a section Oranga Hinengaro (mental wellbeing) providing information on how to get immediate help, access to self help resources and access to services (mental health and addictions).	Q1: Psychosocial Wellbeing Hub will be operational and accessible to Northland community.	Reporting by quarter on number of views/ accesses to the Oranga Hinengaro section of the site.
2 *Mental Health and Addictions Telehealth action plan* will support process and capability to offer choice and access options to receive in virtual care and treatment as well as in person face-to-face.	Q1: MHAS will have a Telehealth action plan in place. Q2: workforce and service user training developed and delivery commenced. Q2: policy and protocol framework developed. Q3, Q4: reporting of telehealth performance data.	Telehealth Action Plan. Training program and schedule. Number of telehealth contacts – Māori and non-Māori. Type of telehealth contact Māori and non-Māori.
COVID-19 resurgence plans in place that include a focus on supporting the psychosocial response		
3 *Mental Health and Addictions Resurgence Coordination Pathway* will ensure access across sector (Primary Mental Health Coordinators, General Practice HIPs, Health Coaches, and Specialist Services Primary Care Liaison) to appropriate and responsive psychosocial resources and services during Covid-19 alert levels 2-4.	Q1: Primary Mental Health Implementation Group workshop. Q1: pathway development. Q2: pathway training and orientation.	Q3/Q4: in response to Covid-19 lockdown – alert level 3 or 4. 90% services users navigated through pathway as appropriate.
4 *Prioritisation screening:* Specialist MHAS clients all have pre-screening for vulnerability and barriers to telehealth access to enable prioritising in event of resurgence.	Q1: implementation of prioritisation screening tool in Jade. Q1: tracking dashboard implemented.	80% of active clients are screened reported each quarter.
Improving mental wellbeing		

DHB activity	Milestone	Measure
5 New Home Based Treatment (HBT) service development.	Q1: service model development. Q1: performance measures. Q1: workforce recruitment and orientation. Q1: service commencement. Q4: service evaluation.	# of service clients, Māori and non-Māori. # of contacts, Māori and non-Māori. LOS with service, Māori and non-Māori. Honos entry and exit matched pairs, Māori and non-Māori.
6 *Individual Placement and Support (IPS) Programme.* Two new sites, Kaikohe and Kaitaia, with focus on high level of integration with Māori communities.	Q1: engagement of a Māori provider. Q1: workforce recruitment. Q1: orientation and training. Q1: service commencement. Q3: independent service evaluation IPS fidelity review.	# referrals, Māori and Non Māori. # clients gaining employment, Māori and non-Māori. # clients entering vocation training programs or tertiary education, Māori and non-Māori.
Follow-up within seven days post-discharge from an inpatient mental health unit (MH07)		
7 *Community discharge responsiveness Improvement Initiative.* Actions include: • increasing focus on discharge and follow up in daily and weekly team forums lead by Team Leaders and Clinical Leads • development of daily reporting to support follow up post discharge • improvement of data capture into Jade • improvement of case manager allocation prior to discharge	Q1: automated daily prompt report to team leaders identifying all people discharged requiring 7 day follow up. Q2: admission to discharge pathway mapping.	MH07 % post discharge follow up reported each quarter. % clients with allocated case manager on discharge.
8 Review of the quality of 7 day follow-up contacts.	Q1: audit tool development defining criteria for a quality contact. Q1: random sample audit, establish baseline and target set. Q2, Q3, Q4: audit. Quarterly: evaluation and report back at team level.	Q1: identify baseline and target %. Comparator audit result reported for each quarter against set target.
Two locally selected contributory measures from the KPI programme		
9 *MH03: transition / discharge planning:* discharge coordination initiative.	Establishment of discharge coordinator role. Q1: review of nursing discharge summary. Discharge coordinator to participate in review of admission to discharge pathway.	# people discharged with pre-arranged community appointment. #people with whānau hui prior to discharge.

DHB activity	Milestone	Measure
	Improve processes for engagement of whānau in discharge planning.	
10 Reduce 28 day acute readmission rate.	Discharge coordination initiative.	# people with current relapse prevention plan on discharge. Reduction of 28 day acute readmission rate from baseline.
11 Actions to support Zero Seclusion. Focus areas for 2021/22: • reduce seclusion events and durations for known* service users in the first 48 hours from admission • eliminate first seclusion events for service users 48 hours or more from admission * For the purposes of this action we are going to focus on a specific group of known service users. These are defined as "the 15 service users with a current open case to a community mental health team who have had the highest number of seclusion events over the previous two years".	Q1 development of specific plans to address focus areas. Establishing baseline measures. Q2, Q3 PDSA testing of ideas. Q4 evaluation of progress.	20% reduction in events and durations for known service users in the first 48 hours from admission, split of Māori and non-Māori, calculated over a rolling 12 months and reported quarterly. 20% reduction in first seclusion events for service users 48 hours or more from admission, split into Māori and non-Māori, calculated over a rolling 12 months and reported quarterly.

2.5 Improving wellbeing through prevention

These linkages above apply to all priorities under 2.5	***Government theme:*** Improving the wellbeing of New Zealanders and their families	
	System outcomes	***Government priority outcomes***
	We have improved quality of life	Support healthier, safer and more connected communities

2.5.1 Communicable disease

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

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

2.5.2 Environmental sustainability

DHB activity	Milestone	Measure
1 Implement travel avoidance and other travel mode shift opportunities that reduce greenhouse gas emissions and promote health.	Q2: Analyse and prioritise all travel avoidance and alternative modes of transportation options such as flexible working arrangements – work from home; shared transport options for commute, business and/or patient travel, fleet optimisation and promotion of active travel (walking, running and cycling to work). Q4: Implement at least three of the prioritised actions.	
2 Integrate Te Ao Māori and mātauranga of tāngata whenua in our sustainability approach.	Q2: Commence engagement with our Māori directorate and other iwi partners to develop the stepping stones and framework principles used for our next sustainability strategy. Q4: Have an agreed Te Ao Māori centred sustainability framework.	
3 2020/21 carbon emissions report with third party verification. Transition half the light fleet (150 fleet cars) to EVs.	Q2 Verification report. Q4 150 EVs in fleet.	

2.5.3 Antimicrobial resistance

DHB activity	Milestone	Measure
Primary care		
1 *Consumer education.* Implement a consumer awareness programme focussed on education of antimicrobial resistance and the importance of using antibiotics appropriately.	Design a consumer campaign to target awareness of viral / bacterial infections, prevention and AMR. Requirements of a promotional campaign include learning from Covid-19, personal hygiene and culturally accessible messaging is established. Expand promotion of World Antibiotic Awareness Week. By Q2.	Number of providers (including general practice, pharmacy, and Māori health providers) receiving resources, tools or advice. % of sample satisfied or very satisfied with the resources, tools, or advice they received. % of Māori providers who were satisfied or very satisfied with the resources, tools or advice received.
2 *Provider resources/ education.* Provide all prescribers, pharmacy, health care team members stewardship resources and prescribing guidance that is based on latest messaging and evidence for best practice.	Appropriate resources and prescribing guidance with local microbiologist approval made available to prescribers and relevant health care team member throughout the year. Up-to-date antibiotic prescribing guideline sent to all prescribers and available on stakeholders' websites.	Review of # antibiotics dispensed per person per year per provider.

DHB activity	Milestone	Measure
	Quick reference checklist developed for general practices to ensure level responses triggered by Covid-19 community outbreaks are timely. By Q3.	Provider feedback monitoring.
3 *Infection control/ prevention.* Improve the rate of all immunisations, including Covid-19, with a focus on priority populations and Māori. ***EOA***	Use primary care data to proactively identify priority population groups that require immunisation	
	Across the sector align appropriate messaging for priority populations and key vaccinations.	Monitor the uptake of immunisation for Māori whānau.
	Utilise educational tools that will support specific population need – that is, Māori whānau	
	Improve the quality and uptake of MEDINZ communications to general practice By Q4.	Track and monitor the utilisation of MEDINZ communication
Hospital		
1 Clinical audit for 2021: Out Patient Antibiotic Treatment (OPAT) outcomes.	Data collected from start of program March 2019 to current Clinical audit data are collected weekly. Report will follow in Q1 2021/22. Covid-19, RCPA and ESR EQA results are evaluated on an ongoing basis as part of the laboratory's QA. Covid reagents are monitored daily as part of good laboratory practice.	Measure adverse drug reactions, line complications, length of therapy, IV to oral switch, mortality. Compare oral vs iv treatments for failures, mortality morbidity
2 Covid-19 contribution: • rapid testing for Whangarei hospital patients and staff members • two different platforms validated for Covid-2 testing • vaccine roll-out as per MoH guidelines.	Monitor daily reagent consumption. Tests approved by IANZ, NDHB reimbursement to commence. Roll out meetings.	Average 3 tests/day, capacity of 60 tests per day, current reagents for 400 tests. RCPA EQAs. Number of staff vaccinated.
3 Continue to report on: • de-labelling testing and patient education • surveillance of ethnic groups who are disproportionately affected by Methicillin-resistant Staphylococcus aureus (MRSA), Carbapenemase-producing Enterobacteriaceae (CPE), Vancomycin Resistance(VMR), C. difficile rates, TB (MDR), Drug resistant N. gonorrhoeae etc • UTI, skin, GIT etc to assess compliance antibiotic use covering primary care, ARRC, hospital-wide)	All topics mentioned are monitored by our Hospital Infection Control Team and reported quarterly as KPIs.	
ARRC		

DHB activity	Milestone	Measure
1 Establish a clinically led collaborative for selecting, implementing, testing and monitoring antimicrobial stewardship in Aged Residential Care services.	Q3: following completion of current project in conjunction with HQSC there will be an evaluation and plan for the next steps. Q4: roll the project out to ARRC facilities.	
2 In partnership with HQSC we will be involved with the development of clinical decision guidelines from the collaborative work from last year, and these will be incorporated in the updated frailty guide utilised by ARRC providers. This will be the mechanism to spread the improvement work from last year's plan.	Q1-Q4.	

2.5.4 Drinking water

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Undertake activities and report on performance measures as per the Drinking water exemplar planning & reporting template 2021/22 for Public Health Units	Q2 & Q4 reports provided.	Reports are approved by the MOH.	
2 Q1 complete the annual review compliance reporting for 2020/21. Northland DHB will highlight non-compliant supplies, or water supplies which predominantly serve Māori or Pacific, or those which potentially pose a public health risk, to Taumata Arowai at handover.	# of compliance reports completed. Q1 and ongoing.	% of reports completed within required timeframes.	

2.5.5 Environmental and border health

DHB activity	Milestone	Measure
1 Undertake activities and report on performance measures as per the Environmental and Border Health Exemplar planning & reporting template 2021/22 for Public Health Units, including hazardous substances; border health; emergency planning and response; resource management, regulatory environments and sanitary works; and other regulatory issues.	Q2 & Q4.	

Recreational water

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Encourage local authorities to clearly identify, and publicly notify, existing or potential recreational waters, which do not meet minimum microbiological water quality guidelines in the Ministry of Health/Ministry for the Environment Microbiological Water Quality Guidelines for Marine and Freshwater Recreational Areas. ***EOA***	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities to improve public access and community safety while accessing recreational waters in Northland.	% of activities aligned with Ministry of Health and DHB priorities. % of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
2 Work with Councils to provide public health advice on strategic long-term planning regarding urban development whilst ensuring focus is aligned with the priorities of Māori in Northland.	*Narrative reporting:* A summary of Ngā Tai Ora's submissions on Council plans and strategies.	% of activities aligned with Ministry of Health and DHB priorities.`	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
2 Encourage the grading of bathing beaches, as outlined in the Microbiological Water Quality Guidelines for Marine and Fresh Water Recreational Areas.	# of recreational water incidents and inquiries attended to.	% of incidents and inquiries attended to as per the Health Protection manual.	*Narrative reporting:* Nil.
3 Respond to recreational water incidents and inquiries as required.	# of suspected or confirmed cases of toxic shellfish poisoning investigated.	% of investigations carried out as per the Ministry of Health regulations.	*Narrative reporting:* Nil.
4 Investigate cases of suspected or confirmed toxic shellfish poisoning.	*Narrative reporting:*	% of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:*

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
	A summary of Ngā Tai Ora's advocacy activities related to recreational water quality.		A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
5 Provide input into regional and local activities associated with recreational water quality. Provide public and stakeholders with appropriate advice relating to recreational waters (eg public health fact sheets, media releases, updated website information).	# of advocacy activities undertaken.	% of information provided/advocated is consistent with the Ministry of Health guidelines.	% of public and school swimming pools in Northland that meet the NZS5826: 2010 Pool Water Quality requirements.
6 Encourage territorial authorities and pool managers (including school pools) to implement the requirements of NZS5826: 2010 Pool Water Quality to avoid or reduce public health risks.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities to improve public access and community safety while accessing recreational waters in Northland.	% of activities aligned with Ministry of Health and DHB priorities.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.

Wastewater

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Conduct routine evaluation of the performance of controlling authority management of public health aspects of sewage collection and disposal with reference to statute, guidelines, standards, resource consent conditions and accepted public health practice.	# of evaluation activities undertaken.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
2 Investigate and assess, with an equity focus, the public health need for sewerage systems in areas not adequately serviced.	*Narrative reporting:* A summary of activities undertaken.	*Narrative reporting:* Nil.	*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to improved health outcomes.
3 Undertake sanitary and waste surveys as required.	# of sanitary surveys conducted by Ngā Tai Ora (if it is within the Ngā Tai Ora's responsibility).	*Narrative reporting:* Nil.	*Narrative reporting:* Nil.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
4 Provide a system for monitoring of significant public health risks in waste management.		*Narrative reporting:* Nil.	*Narrative reporting:* Nil.
5 Liaise with councils to verify that sewage overflows that pose a significant public health risk are adequately responded to, engage with sewage collection and disposal providers to ensure overflows are appropriately managed and reduce overflows to high risk areas.	# of sewage spills attended to.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to reduced public health risks.
6 Promote, with an equity focus, improvements in public sewage collection and disposal systems where this is considered necessary.	# of advocacy activities undertaken.		*Narrative reporting:* A summary of Ngā Tai Ora's actions/ contributions leading to reduced public health risks.
7 Investigate, with an equity focus, clusters and cases of illnesses associated with non-occupational exposure to sewage or other waste. ***EOA***	# of investigations undertaken.		*Narrative reporting:* A summary of e actions/ contributions leading to reduced public health risks.

Hazardous substances

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Use the priority criteria in the Hazardous Substances Action Plan, and injury surveillance data, to develop hazardous substances programme plans. Report all notifications of hazardous substances injuries, including agrichemical spray-drift complaints, lead poisoning and poisoning arising from chemical contamination of the environment, to the science provider in the format required,	# of public health HSNO enforcement officers. # of hazmat incidents or emergencies attended. # of cases of hazardous substances injuries that are notified by GPs, hospitals and others.	% of routine applications for Vertebrate Toxic Agent (VTA) permissions processed within 20 working days. *Numerator:* # routine applications processed within 20 working days. *Denominator:* # routine applications.	#/% audited VTA operations compliant with permit approval conditions. *Numerator:* # audited VTA operations compliant. *Denominator:* # audited VTA permissions.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
including General Practitioner (GP) notifications.			
2 Promote hazardous substances injury notifications by GPs. Participate in the Hazardous Substances Injury Surveillance System and other notifiable condition surveillance systems, including GP notifications via the Hazardous Substances Disease and Injury Reporting Tool (HSDIRT) system and according to Ministry of Health guidelines and direction.	# of VTA complaint investigations received and investigated. # of VTA complaints referred to another agency. # of response plans reviewed and revised, if necessary, following responses and exercises.	% of 1080 operations with permissions audited, either by desktop or field audit, for compliance with permission conditions (expected 100%). *Numerator:* # 1080 operations with permissions audited. *Denominator:* # 1080 operations with permissions.	*Narrative reporting:* Outcomes of promotion of the HSDIRT reporting process to GPs, hospitals and others.
3 Investigate notifications of lead poisoning, poisoning from chemical contamination of the environment, and hazardous substances injuries as required.	# of investigations/activities undertaken, by type (eg crayons, face paint, chemical spills).		
4 Audit compliance with, investigate breaches of, and where appropriate, enforce the relevant Acts and Regulations, including: • attending hazardous substances incidents as requested by Fire and Emergency NZ • surveillance of hazardous substances injuries and reporting via the HSDIRT system.	# of applications for Vertebrate Toxic Agent (VTA) permission received. # of applications for VTA permission issued. # of desk top audits of 1080 operations. # of field audits of 1080 operations. # of desktop or field audits of non 1080 operations. # of HazMat exercises attended.	% debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines, including the National Hazmat Response Plan, Major Response to Fires; guidelines for public health units (Revised 2014), Investigation and Surveillance of Agrichemical Spraydrift Incidents: guidelines for public health units. *Numerator:* # debriefs/audits that show that response was consistent with Plans, Ministry Guidelines, etc. *Denominator:* # of responses.	
5 Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk, for example, through assisting with recalls and public warnings as required.	# of area HazMat coordination committee meetings attended.		
6 Receive annual reports on methyl bromide fumigations. Maintain effective risk management strategies and response plans for HazMat incidents and emergencies, including			

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
deliberate chemical contamination and chemical fires, and including at designated points of entry. Responses are required to be consistent with the Ministry's advice and guidelines as noted in the service delivery expectations.			
7 Represent public health interests at meetings of the Area HazMat Coordination Committee. Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment by: • providing public health advice and information on hazardous substances and products to the public, health professionals and organisations • advising on the safe management of hazardous substances and products, including their removal and disposal from contaminated areas • advising on the safe management of asbestos in the non-occupational environment according to the Ministry of Health's guidelines and direction. • advising on the safe management of products containing lead, including lead-based paint and mercury (including its removal and disposal).	# of meetings attended.		*Narrative reporting:* Outcomes of hazmat meetings and exercises.
8 Advise, encourage and/or assist territorial authorities and Regional Councils to: • identify potentially contaminated sites in the region and identify contaminants • implement health impact assessment systems to ensure contaminated land is remedied, where appropriate, and to minimise adverse effects on human health	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities.		*Narrative reporting:* Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
• determine appropriate land use controls for contaminated sites to minimise the risk to the public • ensure appropriate advice is provided to manage any public health risk from sites and during any remediation processes.			

Mosquito surveillance

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

Border health

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

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
4 Respond promptly to requests for pratique, inspections and certification (eg ship sanitation).	# of maritime pratiques issued. # of maritime pratiques issued on arrival. # of aircraft met on arrival. # of ship sanitation exemption, extension and control certificates issued.		
5 Attend border and other intersectoral meetings with relevant agencies and organisations on matters relating to border health protection.			
6 Provide sound technical and professional advice on public health issues that are related to border health protection objectives in relation to imported risk goods, disease vector surveillance and control, preparation of contingency plans for emergency response, preparation of submissions as appropriate on proposed pest management strategies.			
7 Provide public health training to air and sea port staff, as required, on border health protection risks and their management.	# of public health training (eg advice, update, event) to air and sea port staff.		
8 Contribute to or lead (when required) the preparation of equity-focused health impact assessments in relation to border health protection threats and eradication and control activities. ***EOA***			
9 Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.		% of current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course (expected 100%). *Numerator:* # current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course.	

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
		Denominator: # current staff members involved in ship sanitation inspections.	

DHB activity	Milestone	Measure
Support COVID-19 recovery/embed learnings		
10 Continue to focus on the border worker and household contacts of border worker cohorts of the Covid-19 vaccination rollout, including priority populations (Māori and Pacific) within those cohorts with input from external partners (such as employers, iwi) in the most appropriate ways (including communication, venues) to maximise cohort engagement and vaccine uptake. ***EOA***	Ongoing	
11 Manage extension of the Northern Region's vaccination programme to include priority groups (as indicated by the Ministry) within the general population through co-developed strategies with Māori and Pacific community partners, venue selection and communication activities. ***EOA***	Ongoing	

Emergency planning and response

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
1 Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies and according to Ministry of Health guidelines, plans and advice, and with an equity focus. ***EOA***			
2 Maintain and review Emergency Response Plan(s). There must be plans covering the following minimum areas: • Border Health Response	# of responses.	% of public health unit plans include reduction/readiness/response/recovery/resilience, and identify resources needed to support and carry out public health action (expected 100%).	#/% of Ngā Tai Ora Emergency Planning and Response Plan interoperable with stakeholder plans (that is, TAs, DHBs, airport, seaport).

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
• Communicable Disease – Outbreak/ Pandemic • Hazardous Substances (including radiation, hazmat responses, and Chemical and Biological Counter Terrorism Response) • Civil Defence/ National Disaster.		*Numerator*: # public health unit plans include the four 'Rs'. *Denominator:* # public health unit plans.	*Numerator:* # interoperable Ngā Tai Ora /stakeholder plans. Denominator: total # stakeholder plans. *Narrative reporting:* Please report in narrative, if plans are not interoperable, on how you are working towards making plans interoperable. Definition of interoperable: The two Plans operate together seamlessly, are aligned and there is no discontinuity (eg if the airport EOC incident controller role is undertaken by the Police, then that is documented in the Ngā Tai Ora Plan).
3 Take appropriate equity-focused emergency actions, as the need arises. This includes liaison with and taking directions from other agencies involved, including providing services for, be directed by, and report to civil defence authorities. ***EOA***		% of plans and Standard Operating Procedures updated each year (required 100%). *Numerator:* # plans and Standard Operating Procedures updated. *Denominator:* plans and Standard Operating Procedures. Note: As a minimum the annual update should include a check to ensure that relevant contact phone numbers are still correct.	*Narrative reporting:* Outcomes of exercises. #/% of Health Protection Officers and Medical Officers of Health graduated from Coordinated Incident Management System (CIMS) 4 or CIMS (Health) training within the last four years. *Numerator:* # Health Protection Officers and Medical Officers of Health graduated from CIMS 4 or CIMS (Health) training within the last four years and currently employed. *Denominator:* # Health Protection Officers and Medical Officers of Health. *Narrative reporting:* If not 100%, please report on when they would be completing this training. Note: target should be 100% over a four-year period.
4 Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies, including	# of exercises.	% plans tested, including emergency communications (required 100%). *Numerator:* # plans tested. *Denominator:* # plans.	

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	Quality of effort (How well did we do?)	Quantity and quality of effect (Is anyone better-off?)
national, regional and local meetings, exercise and training opportunities.		Note: checking that all emergency phone numbers are still correct as a minimum.	
5 Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/ CIMS.		*Numerator:* # exercises and responses followed by a debrief. *Denominator:* # exercises and responses. Note: If the exercise is held by another agency and there is no debrief, the Ngā Tai Ora should hold its own debrief.	
6 Ensure key health messages are available in educational and promotional materials through collaboration with other agencies/organisations involved in emergency planning and response.		% of debrief recommendations that are incorporated into plans and SOPs. Numerator: # debrief recommendations that are incorporated into plans and SOPs Denominator: # debrief recommendations.	

Other regulatory issues

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

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
• monitor territorial authorities' actions on these issues to ensure health impacts are minimised • respond to public enquiries and investigate and/or redirect public complaints and queries on these issues. Support local government implementation of national policy statements and national environmental standards. ***EOA***			

Disinterment

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

Solaria

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

Laser pointers

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

2.5.6 Healthy food and drink environments

Ngā Tai Ora, Public Health Northland Activity	Measure		
	Quantity of effort (How many did we do?)	**Quality of effort** (How well did we do?)	**Quantity and quality of effect** (Is anyone better-off?)
1 Review the DHB 'Healthy Food and Drink' policy and align it with the national policy and to introduce 'water only' in the policy. Develop an implementation plan to implement the policy across the DHB.	*Narrative reporting:* A summary of Ngā Tai Ora's advocacy activities and progress made.		

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

2.5.7 Smokefree 2025

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

DHB activity	Milestone	Measure
3 Based on the 2020 Covid-19 environment in the winter months, Māori health providers will continue to deliver opportunistic Stop Smoking Services along with health checks with whānau in the months of July to Dec while flu and Covid-19 vaccinations are being implemented – holistic responsiveness to whānau regarding support to quit smoking.	Q1 and Q3.	
4 Increase enrolments of Māori, wāhine Māori and hapū mama to Stop Smoking Service. Smokefree Kaitaia provides Hapū mama Incentive Programme. Education and resources provided at Hine Koopu Hapū Wānanga.	Q2, Q4.	# self-reported and CO-validated quits increases for: • Māori • wāhine Māori • hapū mama.

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

2.5.8 Breast screening

DHB activity	Milestone	Measure
Outcome: Achieve target breastscreening coverage for women of all ethnicities within two years (as at Jan 2021 Northland's coverage is Māori 62.6%, Pacific 59.5%, total 62.0%).		
1 Implement a programme to reduce the equity gap for women who are eligible for a breast screen.	Q1: design of a recovery action plan (including Covid-19 recovery) for capacity and access with a priority focus on Maori and Pacific women. Q2-Q4: implementation of the action plan. Q4: 65% coverage for Maori and Pacific women is achieved.	65% for all women by the end of 2021/22. 70% for all women by the end of 2022/23.

2.5.9 Cervical screening

DHB activity	Milestone	Measure
1 Increasing the number of smear takers and improving competency of the workforce is a key area of focus for 2021/22.	Q1-Q4: drive to increase workforce through additional smear taker training. Q1: formalise a workforce development plan.	
2 Embed quarterly breast and cervical regional meetings as a means to monitor cervical screening rates and share information across all providers, DHB, PHE, Māori and Pacific health providers.	Q1-Q4: Breast and cervical regional meetings Māori and Pacific health providers will use these forums to share guidance to improve cultural competency and safety across all providers. This will also be formalised through the workforce development plan.	
3 Health promotion activities will be undertaken, targeting priority women thorough community events, targeted campaigns and home visiting initiatives.	Q1-Q2: • 'Smear te mea' campaign led by Te Hiku Hauora • Fale Pasifika is developing messaging around a new home-visiting model of care to engage women with breast and cervical screening. This will be led from Whangarei but rolled out across Northland. They will take referrals and self-referrals. • Ki A Ora Ngatiwai attending community event in Bream Bay	
4 Develop further initiatives to target free screening funding for Māori and Pacific women, in order to eliminate gap in screening coverage as a result of Covid-19.	Q1: contracting in place. Q1: Implementation begins.	Backlog of estimated 220 Maori women overdue for screen eliminated.
5 The service will review the ability to provide outpatient LLETZ (large loop excision of the transformation zone) treatments in the clinic for the women in the Far North and	Q1-Q4. Q3: the service will investigate the feasibility of this and review in 6 months.	

DHB activity	Milestone	Measure
Kawakawa. This would reduce the transport / cost of petrol barrier to attendance.		

2.5.10 Reducing alcohol-related harm

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

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

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

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

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

It is something that would have made a difference.

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

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

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

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

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

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

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

2.5.11 Sexual and reproductive health

DHB activity	Milestone	Measure
Northland DHB context There is a significant overlap in the aspirations of our actions outlined in 2.3.3 for youth mental health and wellbeing with the alignment to sexual and reproductive health of youth specifically through the burden of disease created through sexually transmitted infections. Northland has focussed on the development of a single Northland-wide sexual health promotion plan for rangatahi and youth living in rural areas. The health promotion plan is guided by and evidences key documents and approaches: • Te Tiriti o Waitangi • NDHB Sexual Health Strategy • Ngā Tātai Ihorangi toolkit.		
1 Implement a new model of service delivery in partnership with key stakeholders.	Increased provision of outreach nurse-led clinics, community youth workers and GPwSI consults for sexual and reproductive health across the region.	
2 Establish a key stakeholder group to inform our health promotion plan and key agreed messages that are then aligned with Ngā Tātai Ihorangi framework.	Q2: key stakeholder group established and first draft plan completed.	

2.5.12 Cross-sectoral collaboration including Health in All Policies

DHB activity	Milestone	Measure
1 Provide strong leadership for public health policy by proactively identifying opportunities to influence agendas locally and nationally.	Q2&Q4: expand the PHU relationships and influence with local councils and facilitate the sustainable implementation of equity-focused Health and Wellbeing in All Polices (HWiAP) across all of council. Q2&4: co-develop a strategy to embed HWiAP at all levels across all sectors in Northland, including opportunities for evaluation and monitoring of HWiAP in Northland. HWiAP includes a focus on equity. Q2&4: make timely and professional submissions on national and regional plans and policy statements, district long term and annual plans and, where appropriate, resource consent applications to ensure that equity-focused public health effects are considered and managed. Q2&4: Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that equity-	Health and Wellbeing in All Policies approach adapted by councils. Submissions undertaken that promote public health policy. HWiAP strategy adopted.

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

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

2.1.2 Whakamaua: Māori Health Action Plan 2020-2025 action 1.2. 2.2.1 Short-term focus – 2021/22 action 1 third bullet. 2.3.3 Youth health and wellbeing both actions.

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

These linkages above apply to all priorities under 2.6

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

2.6.1 Delivery of Whānau Ora

DHB activity	Milestone	Measure
Support Covid-19 recovery/ embed learnings. The unregulated/community support/navigator workforce were critical to the agile models that Māori health providers and the Whānau Ora Collectives employed in response to Covid-19. We will continue to work with the NRHCC to fund these roles, and support with developing and training this workforce to take on more responsibility for their communities.		
1 Continue to invest and support for Clinical and Kaimanaaki/ Whānau navigator roles within Maori Health Providers.	Q2: New clinical and Kaimanaaki FTE invested in with Māori health providers Increased. FTE are recruited by Maori NGOs. Q4: Māori students within the community are completing their qualifications in their chosen course of study through HWNZ funding support.	
2 Offer professional development opportunities to this workforce through Health Workforce NZ.		

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

DHB activity	Milestone	Measure
1 Northland DHB is committed to implementing Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025.	By 31 July 2022: a planned restructure within Northland Pacific Island Charitable Trust (Fale Pasifika) to be implemented to build capability and capacity for 2021/ 2022:	
	Employ 1.0FTE	
	2) Regional reps/ champions identified for Te Tai Tokerau four regions	
	3) Communications Plan for consumers, stakeholders and service users. Develop in Group 3 COVID19 vaccination rollout	

DHB activity	Milestone	Measure
	4) Redevelop website	
	5) Strategic and Quality Plan	

2.6.3 Health outcomes for disabled people

DHB activity	Milestone	Measure
1 Support NDHB to become a more accessible and inclusive employer by working with Accessibility Tick Limited, concentrating on their nine areas of competency: commitment, physical environments, recruitment and selection, employer support/ workplace adjustments, communication and marketing, products and services, information communication technology, career development, suppliers and partners.	Q1: annual high level assessment/gap analysis. Q1- Q3: create objectives & action plan to achieve them. Q4: achieve the Accessibility Tick.	
2 Engage with the Regional Psychosocial network to identify emerging community issues for vulnerable people in the community impacted by Covid-19.	Q1: identify key stakeholders and establish meeting schedule. Q2E establish ToR and reporting framework.	

2.6.4 Planned Care

DHB activity	Milestone	Measure
The full realisation of a Planned Care Three Year Plan is a huge exercise because improving equity, access, quality, timeliness and experience for all patients involves changing (or even rebuilding) the current system. It is not an exercise that Northland DHB can do alone. Involvement is needed from across the Northland health sector, especially from primary care because what happens in health services in the community drives the needs that reach hospitals. Northland DHB is currently developing a Strategy 2040. There has been an extensive engagement process and we are in the process of developing high-level themes and directions. The Strategy takes a sector-wide approach in recognition that, as indicated in the Health and Disability System Review, fundamental changes need to happen to the current health system if it is going to achieve equity for all and meet current and future challenges. The Planned Care Three Year Plan is a natural fit with the Strategy and will evolve out of and alongside it.		
1 Develop new models of care in collaboration with primary and secondary sectors that can improve equity, timeliness and access as well as patient experience.	Q1-4: identify opportunities for patient referrals to be redirected to Primary Support Services prior to FSA (involve Multi-Disciplinary Team). Q2: develop processes across secondary care that identify priority populations (Māori, rural, low-socioeconomic) to facilitate First Specialist Appointments.	Number of referrals that identifies the vulnerable patient increases by 5% per month commencing once RMS enables identification by referrer. Number of DNA for OPD and procedures will decrease by 2% annually by Nov 2021.

DHB activity	Milestone	Measure
	Q3: develop relationships across planning and funding of primary and secondary care services to identify opportunities for shifting appropriate care and procedures into the community. Q3&4: develop a Planned Care action plan in response to the Northland Health 2040 strategy.	Customer satisfaction measure will be developed and offered. Monthly review of 10% of those identified as vulnerable on referral will be reviewed ensuring quality, appropriate MDT involvement and consistent care.
2 Develop the internal electronic register of all clinical staff skill sets, capabilities and work preferences that was developed as part of the Covid-19 response. This will be used within Whangarei Hospital's nursing bureau as part of BAU, and to support coordination of ongoing learning/ maintenance of high dependency/ ICU care in the event a pandemic requires this response.	Ongoing.	
3 Actions to meet the five priority areas:		
3a Equity: Work with the primary sector to develop an alert case management system that identifies vulnerable patients and wraps the right care around them to improve equity and access.	Q1-Q4.	
3b Access: Develop a model of patient centred care that provides the right treatment to the right patient, in the right time at the right location with the right information which is understood by the patient. We want this model to alert secondary care to patients requiring specific support that enables them to access care in a timely manner and to present in an optimised state for surgery.	Q1-Q4.	
3c Quality: Develop improvement programmes from hui consultation and surveys (see 3e).	Q1-Q4.	
3d Timeliness: Increase theatre capacity by opening a second theatre in Kaitaia and opening two further theatres in Whangarei.	Q1-Q4.	
3e Patient experience: Hold hui and undertake surveys, including all members of the health team (primary sector, NGOs, Iwi), to understand the problems people face with our health service and how we make them feel.	Q1-Q4.	
4 Continue to work with the Ministry and the NRA to develop local implementation and operationalisation of regional services in Northland. In particular the Vascular Regional Service Oversight and Ophthalmology Regional		

DHB activity	Milestone	Measure
Service Oversight groups to support regional/ national consistency in referral acceptance and management.		
5 Mobile diagnostic bus (the Peoples Bus) to coordinate and support access of diagnostic assessments, closer to home. Specifically targeting the reduction in wait volumes and time for Echo and maternity USS. End-to-end review of Echo diagnostic pathway has commenced.	Q1 complete initial review of wait list	
6 Measures contributing to Planned Care are acute bed days and ASH rates for 0-4 year olds (contained within Appendix 2 System Level Measures Improvement Plan 2020/21.		Milestones: Acute bed days: Reduce the equity gap by 5% between Māori and non-Māori in the 45-64 age group (Baseline Dec 2019). ASH 0-4: Reduce ASH events for tamariki Māori by 5% (28) (based on Dec 2019 baseline of 558 events.

2.6.5 Acute demand

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

DHB activity	Milestone	Measure
1 Implement Manaaki Mana programme in ED to improve equity. ***EOA***	Q1: formalise an action plan from the outcomes of the survey of Maori users to improve equity for Māori accessing the Emergency Department Q3: report on the action plan from the survey Q1: Implement Te Reo signage in the Emergency Department. Encourage all staff in ED to practice the Māori terms with patients. Monitor uptake of Emergency Q vouchers for lower triage Māori patients to access primary care. Te Reo signage in ED is completed. Q4: strategies identified are implemented and reviewed.	Increase % of Māori in the ED workforce. # of Maori nurses in the ED workforce has increased.

DHB activity	Milestone	Measure
2 Redirect appropriate Triage and 5 category patients from ED to primary care by utilising the Emergency Q software.	Q1: analyse uptake of EQ vouchers by Maori patients accessing the Emergency Department. Q2-Q4: if inequities are uncovered, formulate an action plan to address these.	
3a Identify which SNOMED codes should be reported to address priorities such as long term conditions. 3b Explore which other data streams (such as ICD coding from both ED and inpatient events, and outpatient clinic / community nursing data) could be added to SNOMED data to produce a more complete picture of impacts upon Northland DHB's hospital services.	Q4	

2.6.6 Rural health

Northland has a predominantly rural population; two-thirds live outside the Whangārei urban area, many in isolated locations along difficult country roads, and it takes over five hours to travel Northland north to south and up to two hours east to west. Northland DHB is always cognisant of the needs of isolated populations in the planning, delivery and monitoring of our services, and in setting up, negotiating and monitoring contracts with NGOs. Northland's rural and isolated populations form an inherent part of all our planning. Rurality is considered throughout the Annual Plan, both in actions with an explicit rural focus and those that take a Northland-wide view.	
While rural health needs are implicit in all the work we do, they are explicitly addressed in:	
2.2.2 Medium term focus – three years action 1, first bullet. 2.3.1 Maternity care actions 1.2, 1.7. 2.5.4 Drinking water, all actions. 2.5.5 Environmental and border health, almost all actions in all subsections. **EOA** Recreational water, action 1. 2.5.6 Healthy food and drink environments actions 2-7.	2.5.10 Reducing alcohol-related harm action 2. 2.5.12 Cross-sectoral collaboration including Health in All Policies. **EOA** action 2. 2.6.11 Health Workforce actions 1, 3. 2.6.12 Data and digital enablement actions 1, 3, 4.

2.6.7 Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

DHB activity	Milestone	Measure
System outcome: we have improved quality of life.		
1a Following on from successful service development in Falls and Fracture Prevention (FFP) co-funded by ACC and DHB, integrate FFP services into DHB BAU. 1b Enhance equitable provision and reach of Fracture Liaison Service: further service development to achieve National Osteoporosis Foundation silver status (currently bronze). ***EOA***	Q1-4: Fracture Liaison Service is actively managing communication with GPs for patients who would benefit from bone protection medication.	Maintain baseline of 60% of referrals to the high risk falls strength and balance programme being contributed by GPs/ primary health care teams. Increase the percentage of patients presenting to ED with a fall or fragility fracture who are on bone protection medication from 34% to 50%.
2 Revise and expand the model of care for stroke, with a focus on improving stoke outcomes for Māori. ***EOA***	Embed 24/7 hyperacute stroke service utilising ADHB neurology service support and nurse-led local treatment support. Acute Stroke Unit expansion with a kaupapa Māori focus. Implementation of the national stroke rehabilitation action plan. Implementation of the metro-Auckland Atrial Fibrillation detection and management plan.	Stroke KPIs.
3 Develop a proposal for testing the capacity and flexibility of community based non-acute rehabilitation to support hospital capacity, patient flow and improve quality of care.	Proposal completed and implementation commenced. Increase utilisation of regional hospitals for rehab.	ED length of stay (Whangarei Hospital and regional hospitals). <28 day readmission rates by ethnicity, age, locality. Functional goals set at home achieved within 42 days, by ethnicity, age, locality.
4 Progress the work required to implement a nationally consistent Home and Community Support Services (HCSS) Service Specification.	Active engagement in national, regional and local provider service development initiatives. Q1: transition plan completed.	Quarterly progress reports of national, Northern Regional and NDHB provider engagement.
5 Co-design HCSS contracting and service planning to ensure Kaupapa Māori pathways for older Māori and their whānau are retained. ***EOA***	Q3,Q4: delivery of NDHB Equity Framework workshop(s) for contracted providers and whānau Māori consumer representatives. Inclusive transitional service delivery and procurement planning.	# Māori whānau engaged in service design for the transitional nationwide description of HCSS Services. # HCSS providers engaged in service design.
6 Prioritise and progress priority actions identified from the 2019 national dementia care survey. ***EOA*** We are still working with the Northern Region on the dementia plan. Top three priorities identified:	Q1: work with Northern Regional planning and local NDHB context to agree top three regional priorities (via RSP). Q2: develop and agree DHB implementation plans (via RSP).	Quarterly progress reports against NDHB implementation plan.

DHB activity	Milestone	Measure
• improve primary care engagement with the early diagnosis and assessment of dementia • address access to dementia services for Māori • family and whānau supported and involved as early as possible in the dementia journey. Pilot project planned in far North to employ a CNS and care navigator to: • improve capability to deliver diagnoses with training and support to primary and community care • build workforce capacity – enhancing existing kaupapa Māori services and staff who are supporting kaumatua.		
7 Develop inpatient services multidisciplinary team capacity and capability for delivering acute care for the elderly (ACE) model of care. Gerontology assessment in ED. ***EOA***	Increase frailty assessments for those over 80 years of age admitted to medical wards.	#/% 80 + years admitted from ED. <28 day readmission rates by ethnicity, age, locality. Percentage of over 80s admitted to medical wards who receive a frailty screen. Percentage of Māori over 75 admitted to medical wards who receive a frailty screen.
8 Improve preparedness for a pandemic outbreak (and Covid-19 resurgence) on services in the community for older people, using Covid-19 learnings.	Work within the Northern Region Covid-19 planning context to: • support ARRC and HCSS providers to maintain preparedness to effectively respond to COVID-19 matters (ongoing) • support and facilitate the COVID-19 vaccine rollout to aged residential care (ARC) and HCSS providers – timeframe to be confirmed.	NDHB COVID resurgence management plan – and quarterly report on progress. As directed by the MoH.

2.6.8 Improving quality

DHB activity	Milestone	Measure
Hand hygiene. 1 COVID 19 learning reinforced the need to Improve consistent compliance with best practice hand hygiene across the hospital clinical areas and healthcare workers. Increasing the knowledge and monitoring across the organisation to ensure greater than 85% compliance in hand hygiene audits.	As a result of learning from Covid-19, NDHB plans to increase the number of auditors within the organisation by providing 2 hand hygiene auditor training days per year and focussing on auditing all healthcare staff.	Consistently 85% compliance in hand hygiene audits..

<table>
<tr><th>DHB activity</th><th>Milestone</th><th>Measure</th></tr>
<tr><td>2 Continue to progress the implementation of the Quality and Safety Marker for consumer engagement by continuing to support the oversight group of staff and consumers guiding implementation of the marker.</td><td>Q1, Q3: report against the QSM via the online form on the Health Quality and Safety Commission's website using the SURE framework as a guide.</td><td></td></tr>
<tr><td colspan="3">*Improving equity.* Diabetes and associated conditions represent a large proportion of healthcare provision in Northland. Type 2 diabetes and associated conditions are prevalent in Māori at a younger age, significantly impacting on the variance in healthcare outcomes.

Contemporary models of care place the patient at the centre of long term condition management. In order to maximise the potential benefit from this new model of care, healthcare providers must support patients with appropriate, accurate and timely advice. Software which supports the exchange of patient metrics and advice is key to efficient implementation of this model of care. Patient self-reporting and self-management initiatives can have significant benefits for diabetes patients. Promoting and enabling effective self-reporting for diabetes patients in Northland may therefore have the potential to substantially improve both patient outcomes and financial outcomes for NDHB.

Project objectives:
• provide equitable access to text message-based self-management support to people with diabetes in Northland
• improve diabetes outcomes in Northland's patient population
• empower people with diabetes to engage in the behaviours required to manage their diabetes effectively to reduce their risk of diabetes associated complications.

Progress achieved and planned during the first six months of 2021:

Jan: Protocol Design Workshop #1 27 Jan 2021.
Feb: PSG Approve Project Plan -17 February 2021.
Protocol Design Workshop #2.
Mar: Protocol Design Workshop #3.
Solution development and testing completed.
Mar: Security review and cloud risk assessment.
Messaging development and testing.
User acceptance testing.
Evaluation design.
Patient and clinician support material created.
Apr: Handover to Kensington team Early-April 2021.
June: Patient Recruitment 28 June 2021.
June Pilot start.</td></tr>
<tr><td>3 Develop and implement a self-reporting interactive diabetic app.</td><td>Dec: Pilot finish.
Mar: Data analysis and evaluation completed.
Apr: Business case and recommendation to ELT.</td><td></td></tr>
<tr><td>*Consumer engagement QSM.*

4.1 Set up a governance or oversight group of staff and consumers to guide implementation of the marker.

4.2 Submit local data via an online form using the SURE (Supporting, Understanding, Responding, Evaluating) framework as a guide</td><td>By Q3: report against the framework at least annually.</td><td></td></tr>
<tr><td>5 *Zero seclusion project*. See action 11 in 2.4 Improving mental wellbeing.</td><td></td><td></td></tr>
</table>

2.6.9 Te Aho o Te Kahu – Cancer Control Agency

DHB activity	Milestone	Measure
Impact of COVID-19 resurgence. DHBs are required to monitor the impact of COVID-19 on cancer diagnostic and treatment services and use this information to plan and manage service volumes.		
1 Utilise the Cancer and Blood Services Covid-19 Surge Plan 2020 that ensures preparation, process of alternate service delivery and lessons learnt for any Covid-19 resurgence.	Review the impact of Covid-19 2020 and develop/ monitor and assess efficacy of access to cancer treatments.	Patient satisfaction survey. FCT reporting/ breach analysis (pre-post Covid-19).
Equity First. New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawhai.		
2 Cancer and Blood Services will undertake quality improvement work in response to the implementation and reporting of the nationally agreed SACT NZ treatment regimens (national collection) for Medical Oncology and Malignant Haematology.	Develop and implement regional electronic prescribing to enable full reporting of SACT data into national systems (ROES).	Regional positions are recruited into as per timeframes, to enable collection of data to be reviewed regionally and nationally.
3 Work with ADHB to develop a Radiation Oncology service plan that ensures the model of service is fit for purpose to meet the current and future needs of our Northland population.	Continue co-development with ADHB, to implement previously agreed Radiation Therapy Regional Plan (inclusive of our linear accelerator).	Progress towards finalising Business Case to enable what our expectations of the Linac will provide.
Equity First. New Zealanders experience equitable cancer outcomes – He taurite ngā huanga		
4 Support the national work programme for the delivery of local community-based Māori hui in partnership with Te Aho o Te Kahu. From this engagement, DHBs can also facilitate locally driven community-based initiatives with cancer patients and their whānau to drive service improvements.	Continue to build and develop strong relationship with primary health and regional hospitals to take cancer treatment closer to home. Working with BOI Hospital with Phase 2 (building new OPD) with treatment space for a satellite Chemotherapy Unit. Extend Kaitaia satellite service to two days a week. Develop subcutaneous injections and oral chemo to be given in the home (Rawene initiative).	Low did not attend (DNA) rates. Increased patient satisfaction surveys. Faster Cancer Treatment (FCT) reporting favourable results.
Equity First. New Zealanders have fewer cancers – He iti iho te mate pukupuku. NDHB will align our cancer plan with local/ regional screening services, that is bowel, breast, cervical. (Te Aho o Te Kahu will work in partnership with NSU to support delivery and evaluation).		
5 Work closely with the Bowel Screening Programme (NDHB implementing Bowel Screening Programme Go Live 2021).	Support the Bowel Screening Programme (Readiness Assessment) including support for Māori and Pacific patients and enhanced recovery.	Bowel Screening Programme commenced. Participation rates. Align with other measures of reporting (KPIs).
6 Lung Cancer Service Improvement Plan.	Support the Lung Screening Project (nationally).	Await work plan from Te Aho o Te Kahu.

DHB activity	Milestone	Measure
7 Work with Te Aho o Te Kahu to identify actions to sustain or improve local and regional cancer care to meet the 31- and 62-day FCT targets.	Priority given to improve FCT targets, and continue to engage with Regional FCT group to ensure cross-DHB issues are managed.	Reduction in FCT breaches. Improved results regionally and nationally.
Outcome: minimise breeches of the 62-day and 31-day FCT targets and ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway:		
8 Implement approaches to minimise breeches of the 62-day and 31-day FCT targets and ensure equity of access for Māori to timely diagnosis and treatment.	Q1-4: use regional and local performance data and recommendations to streamline tumour stream pathways, particularly where inequity exists, by monitoring quarterly reports to identify improvements required to meet FCT targets. Q1-4: prospective identification, monitoring and intervention throughout the pathway by the CNS Māori/ PI Navigator to enable equity of access. Q1-4: establish networks with iwi providers and psychological support providers to improve equity of access by focusing on high risk Māori / Pacifica. Q1-4: NDHB FCT reporting captures all new and current patients. Q2: stocktake of existing resources and gap analysis. Q1-4: analysis of the patients who did not meet the FCT targets (breech reports). Q3: develop a patient information on cancer diagnosis and treatment for Māori using a health literacy approach.	62 day and 31 day Faster Cancer Treatment targets: 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
Provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer.		
9 Establish post treatment pathways to enable patients to have improved quality of life and to live well beyond cancer.	Q1-4: ensure that patients are referred to Cancer Society for ongoing care (survivorship), while maintaining Medical / Surgical oversight. Q1-4: establish self-care, mindfulness and allied health relationships to develop follow-up care plans for both secondary and primary health. Q1: establish a process to document on PMS (Concerto) “Patient Encounter” to ensure visibility to other services outside Cancer and Blood Services.	Number of patients that receive referrals to complementary services across the system.
10 Move from Vivid Solutions to Zoom with its availability, ability and ease of technology will enable us to join up with our regional meetings.	Q3	

DHB activity	Milestone	Measure
11 As a region work towards standardising our treatment plans and implementing e- prescribing according to the SACT regimens on the TAoTK website – as discussed in Regional Oncology Operations Group.	Q4	
12a Prostate: Improve the triage process at referral. A Prostrate Registry CHOMNZ research project for outcomes for all NZ sand Australian men undergoing any form of treatment generates reports which are sent back to the consultant involved, and then sent to the secure data in Christchurch. 12b Bowel: FCT improvements: review the referral form from primary care to secondary care for colorectal patients.	Q4	

2.6.10 Bowel screening and colonoscopy wait times

DHB activity	Milestone	Measure
1 Implement improvement plans to reduce the wait times for non-urgent colonoscopy.	Q1-Q4: Source additional capacity where required for Twilight and Weekends. Q1-Q4: Ensure ongoing additional locum endoscopists as required for Whangarei and Kaitaia. Q1: Recruitment of additional SMO Gastroenterologist resource. Q1-Q4: Continue priority process for non-urgent colonoscopy over surveillance. Q1-Q4: Implement colonoscopy priority process for Maori to ensure Equity.	Waiting times targets as specified under SS15 in 5 Performance measures: 90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less, 100% within 30 days or less. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less. 70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less. Participation equity gaps are eliminated for priority groups.
2 Report onboarding progress via the readiness process.	Refer to readiness Assessment Bowel Screening.	Readiness Assessment due: • 25/5/21 Kaitaia • 26/5/21 Whangarei.

DHB activity	Milestone	Measure
3 Indicative Go Live NDHB Bowel Screening.	Aug 2021: NDHB Bowel Screening Programme commenced.	
4 Work towards "participation rates for bowel screening priority population groups are at least 60%".	Q4: Post Go Live.	Participation rates as per the R Shiny App.
5 Bowel screening indicator 306 is consistently met.	Q3: Post Go Live.	Consistently meet the bowel screening indicator 306 target that requires 95% of participants who returned a positive faecal immunochemical test (FIT) to have a first offered diagnostic date that is within 45 working days of their FIT result being recorded into the NBSP IT system.

2.6.11 Health Workforce

DHB activity	Milestone	Measure
1 Use the workforce differently, both locally and regionally.	Q3: Provide closer-to-home treatments (such as basic chemotherapy) in the Mid and Far North after further stakeholder engagement.	Number of patients travelling from Mid and Far North to Whangarei Hospital for basic chemotherapy treatment is reduced.
	Q1: Implement the 'Meihana' model and 'Marae encounters model for engagement' as new models of care in the new AU. Educate staff. Co-design with stakeholder and consumer engagement. Equity in Action model designed by MAU staff. Design, develop and implement a patient/ whānau survey based on the new models of care.	Patient feedback. Whānau feedback. Stakeholder feedback. MAU staff feedback.
2 Where possible provide opportunities for employees to work from home.	Q1: In partnership with unions develop and communicate a Working from Home Policy for managers.	Number of staff working remotely increase.
3a Create Māori networks across workforce categories to allow opportunity for Māori staff to connect and reduce isolation.	Q2, Q3, Q4: Stakeholder engagement with workforce leads (Director Scientific, Technical and Allied Health, CNMO). Design, develop and implement networks for Māori nurses, midwives and allied health staff for wellbeing.	Increased retention of Māori staff.
3b Increase representation in leadership and decision making roles	Q2: Establish a Māori leadership caucus to work alongside the Kaunihera	Reduced turnover rates Māori in leadership positions.

DHB activity	Milestone	Measure
	Increase the number of Māori leadership positions. A number of new senior positions are being established. Cultural capital has additional weighting/recognition in recruitment processes. Dashboards available to senior leaders and executives. Further education to hiring managers on Affirmative Action. Māori leadership talent identified and provided greater opportunity for further professional development. Increase number of Women in Executive leadership roles. Increase number of people with lived disability in Executive roles.	The number of Māori in leadership positions has increased. Cultural capital is valued and actively recruited for The number of Women in executive leadership positions has increased. The number of people with lived disability in executive leadership positions has increased.
4 Sustained improvement in number of professionals meeting standards of cultural competence and safety.	Q2, Q3, Q4 Every service uses H&D Service standards to determine a service specific plan/gap analysis to achieve cultural competence and safety needs Review and revise Tikanga Best Practice Guidelines Address complaints of cultural competence and safety aligning to H&D Service Standards	Reduced patient and whānau complaints regarding pronunciation of names and places. Reduced patient and whānau complaints regarding cultural safety. Increased participation on Te Reo courses being held. Increased Te Reo being heard across the organisation. Tikanga is widely known and applied across the organisation.
5 Evolve the Wellbeing strategy over the next 12-18 months specifically for Northland DHB with clear success measures and metrics.	Q1, Q2, Q3, Q4: Recognise that there is a problem. Measuring workforce wellbeing and secondary effects. Increase resource and support service based interventions to progress positive impacts on staff wellbeing. Increase resource acute care interventions for distressed staff.	Intended outcomes: Favourable Employee Exit Survey feedback. Turnover rates reduced. Increased participation on the Wellbeing Index. Greater interest and uptake of Wellbeing initiatives. Reduced bullying. Improved workplace culture. Reduced unplanned sick leave.

DHB activity	Milestone	Measure
6 Use the workforce differently in response to or as a result of learnings from Covid-19 to sustainably build and/or support swabbing and vaccinator workforces.	Q4: Utilise Covid-19 vaccinators to support the (national) Well child Vaccination Schedule to increase rates and address the equity gaps (Māori – non-Māori). Q3/Q4 Engage with Unions via Bi-Partite forum over utilising vaccinators for alternative initiatives.	Equity gap reduced or eliminated.
7 Health and safety:	All milestones and measures are Q1-Q4.	
7a Manage health and safety risks: Safe 365 ongoing monitoring Critical risk/ operational risk/ personal risk		Measured: Safe 365 Maturity Audit Gap analysis across the region
7b Injury management: Review Injury Management process		Internal review of the Injury Management system. AEP – ACC Accreditation audit
7c Verification: External and internal compliance verification		
7d Engagement: Create a Health and Safety Newsletter More face-to-face site visits Focus group for wellbeing	Newsletter input from the Safety Representatives. Set regional visit schedule. National H&S Forum.	

2.6.12 Data and digital enablement

DHB activity	Milestone	Measure
1 *Regional Collaborative Community Care (RCCC) Programme*. Replace Northland's JADE Mental Health and Community Care Information System to provide a regional solution. The vision of the Regional Collaborative Community Care (RCCC) programme is to enable an integrated, collaborative, organised, patient-centred network of primary, community and hospital based care settings for the Northern Region, providing care as close as possible to the home and emphasising prevention (including self-care and health promotion), consumer participation and	Q1: Completion of design phase. Q2: Approval to proceed to build. Q2-Q4: Commencement of implementation.	

DHB activity	Milestone	Measure
consumer autonomy, supported by an integrated technology solution.		
2 *Workspace Programme.* NDHB will leverage the Windows 10 and Office 365 technology upgrade to embed more collaborative and flexible ways of working. Embed key learnings from Covid-19	Q1: Core support team established. Q2: Exemplar workflow innovations established. Q4: Continued rollout.	
3 *Telehealth.* Revise the Telehealth Strategy, deriving from service readiness and future planning with workplans and business cases endorsed and prioritised by ELT. Supporting process and capability of the Telehealth service further matured, including leveraging gains and learnings from COVID.	Q1: Telehealth strategy endorsed by ELT. Q3: Service workplans and business cases developed, work prioritised by ELT. Q1-Q3: NDHB equity framework applied across strategy and workplans. Q1-Q3: Child Health Telehealth Outpatient Clinic Design Group pilot: • Nga Tatai Ihorangi equity framework embedded in user experience service design • End-to-end process designed and piloted comprising clinical eligibility, patient centred booking, pre-appointment communication and appointment experience • Pilot completed and recommendations provided Q3. Q3: Zoom – WebPAS Booking API implemented for Telehealth Outpatient Clinics.	
4 *Cardiac MRI.* Implement a Cardiac MRI service in NDHB to improve access and equity by removing the travel requirements for patients. *Equity of access.*	Q1: Project complete.	
5 Patient Portal Access. NDHB will leverage the capabilities of ManageMyHealth to send patient health documents electronically. *Digital Inclusion.*	Q1: Transfer of Care documents available to be sent to all adult enrolled inpatients. Q2: Patients able to enrol without presenting in person. Q3: Referral notifications available to patients in their portal. Q3: Clinical documents available to patients in their portal.	
6 *ICNet.* Implement an electronic infection surveillance and management system to enable continuous surveying of patients and improved speed of required actions. *Improved Outcomes.*	Q1: Project implementation. Q4: Project closure.	
7 *eVitals.* Introduce an electronic system to capture and record vital sign data, calculate early warning scores and	Q2: Business Case or RFP process complete. Q4: Completion of design phase or completion of business case.	

DHB activity	Milestone	Measure
escalate to the appropriate clinicians. *Improved Outcomes.*		

2.6.13 Implementing the New Zealand Health Research Strategy

DHB activity	Milestone	Measure
1 Conduct quantitative and qualitative research relating to the delivery of Covid-19 vaccinations, particularly including vaccine uptake by Māori and other high risk groups.	Regular monitoring of research progression in this area. Publication of research.	
2 Recruit to a new position of Data Analyst within the Patient Safety and Quality Improvement Directorate, who will provide support for clinical staff engaging in research and innovation activities.	Q1 position appointed. Quarterly review of audit and research activities underway and completed.	
3 Refresh the organisation's Research Policy.	Policy developed and shared across the organisation.	Number of 'hits' on the relevant website.

2.6.14 Care Capacity Demand Management

DHB activity	Milestone	Measure
1 *Governance.* Continue with Safe Staffing Council meetings monthly to provide governance around the programme.	A permanent governance for CCDM is effective and operational for with a CCDM council that has a purpose, values, scope and direction aligned with the organisation's Safe Staffing Council. Safe Staffing Council meets monthly to provide the required membership and the qualified and experienced leadership required. A review of the workplan occurs at each meeting and is recorded in the minutes. Partnership between DHB and unions is evaluated regularly at meetings and also recorded in the minutes.	
2 *Acuity data.* Continue with Trendcare operational steering Group meetings Monitor Trendcare data daily and send out reports for CNMs.	The Trendcare Operational Steering Group is chaired by the Chief of Nursing and Midwifery and meets monthly. The workplan and data are reviewed monthly, and both are recorded in the minutes. A Validated Patient Acuity Committee is attended by key members regularly.	

DHB activity	Milestone	Measure
	The patient acuity system is supported and prioritised as a critical 'service delivery' IT system. Health Alliance prioritises Trendcare as a Tier 1 application.	
3 *Core Data Set.* Continue to collect and monitor the 23 metrics set by the Safe Staffing Health Unit, and use data to drive quality improvement initiatives for Safe Staffing.	The Local Data Councils establish, monitor and act on CCDM data for continuous quality improvement. Safe staffing data is reviewed at each meeting and used to drive quality improvement projects. Data is monitored on a monthly basis.	
4 *FTE calculations.* Continue to use the CCDM staffing methodology to inform the nursing budget annually to ensure a safe level of nursing is achieved.	The organisation has staffing budget setting procedures in place that are reviewed annually by the CCDM council. A robust process is followed for FTE calculations which is recorded in FTE standard operating procedures. All budget holders are met with and have active involvement in the budget FTE process. The organisation uses the CCDM staffing methodology to establish staffing numbers, staff and skill mix for each ward or/ unit that uses a validated patient acuity system.	
5 *VRM.* Continue to respond to variances on a shift by shift basis to ensure safe staffing is achieved and the safety of patient care is maintained.	There is an Integrated Operations Centre where patient flow, bed capacity, staff availability and patient demand is visible in real-time 24/7 across NDHB's four hospitals. Electronic screens are utilised throughout all shifts showing real-time information including the HaaG screen, ED whiteboard and the IOC dashboard. Three meetings are held daily with service managers, general managers and CNM's/ shift coordinators to identify variances so that staff can be moved across areas or bureau nurses used.	

2.7 Better population health outcomes supported by primary care

These linkages above apply to all priorities under 2.7	***Government theme:*** Improving the wellbeing of New Zealanders and their families	
	System outcomes	***Government priority outcomes***
	We have health equity for Māori and other groups	Support healthier, safer and more connected communities

2.7.1 Primary care

DHB activity	Milestone	Measure
1 *Enhanced investment into Tier 1 workforce initiatives.* Northland DHB is committed to significant additional investment into primary care over the coming 12 months to support and sustain our primary care workforce across General Practice, Māori Providers and other NGOs working in the Tier 1 environment. These include dedicated investment into new models of care, a wider workforce blend, GP pipeline initiatives, a health science academy, further after-hours support, GP recruitment bureau and further investment to expedite the development of a comprehensive shared care patient management system.	Q1: Implementation plans approved and funding allocated for at least two of the above themed initiatives. Q4: Four new funded initiatives under way, as well as a clear longer term strategy for encouraging more of today's students across secondary and tertiary education into science based disciplines. These will grow our workforce to reflect the population and ensure we have appropriately skilled staff ready to fill roles vacated by the ballooning retiring worker generation.	
2 *Reduce hospital based interactions.* Continue investment into primary and community initiatives that enable patients, particularly Māori, to receive timely access to care, with an improved patient experience and with interventions that continue to reduce hospital based interactions.	Q2: Whangarei community hub to be in a fully operational state, with experiences and outcomes from this prototype feeding into further expansion of the concept into our rural hospital hubs. Q4: Significantly greater proportion of interventions happening in the community. This population measure must have an equity focus and services must be tailored to ensure avoidable hospital admissions/ episodes for Māori are on track to drop to below 35% of all hospital admissions/ episodes.	

2.7.2 Pharmacy

DHB activity	Milestone	Measure
In 2020/21, Northland he DHB developed a proactive voucher system with our Public Health Unit to encourage eligible Māori, Pacific and other targeted populations to get their influenza vaccine. This included informing patients where they could be vaccinated such as Pharmacy, GP and community pop-up clinics. This initiative supported an uptake in the number of vaccines administered to our population. The rate of influenza vaccines administered improved dramatically and pharmacies were a large contributor to the improved uptake. The DHB will continue this initiative and implement lessons learnt. The COVID-19 pandemic has highlighted community pharmacy's willingness to step up and do even more to support our communities.		
1 Continue to advocate for an increase in the number of vaccinating pharmacies in Northland and an expanded range of vaccinations to be available in Community Pharmacy. This will include Covid-19 vaccines when timely and appropriate. Our community pharmacies offering MMR vaccination continue to be promoted as offering this service.	Q4.	At least five additional vaccinating pharmacies in Northland are able to offer vaccinations as part of their general business.
By the end of Q3 2020/21 we expect to have a Medicines Use Review service pilot underway in 14 pharmacies across Northland. The pilot will run for a six month period and will offer comprehensive support for high-needs patients, and foster close collaboration with general practice and community pharmacy services.		
2 Use outcomes and lessons from this pilot will inform the case for a wider rollout of this service, dependent on funding.	Q1. Q4	Data is collated from MUR services delivered during the 6-month pilot from Mar to Aug 2021 and an assessment has been undertaken to assess suitability of extending the service for an additional term. Subject to approval for the service to continue past Aug 2021, the MUR service is maintained in a minimum of 14 pharmacies, geographically spread across the Northland region.

2.7.3 Long term conditions, including diabetes

DHB activity	Milestone	Measure
1 Operationalise the Northland Diabetes Strategy across Northland. The Strategy has 5 areas of focus, with a specific emphasis on equity and addressing diabetes-related health disparities for Māori: (a) equity, health status and quality of life including prevention for Māori and Pasifika people living with diabetes; (b) allianced leadership between community, primary and secondary services and	Q1: Agreed governance process and action plan for the implementation of the Diabetes Strategy with initial focus on priority activities. As defined in the Diabetes Strategy, year 1 priority activities are as follows: improving the accuracy of diabetes data; increasing the number of Diabetes Annual Reviews; reducing adverse outcomes in podiatry and implementing integrated models of diabetes care	% increase of Diabetes Annual Review rates, with a key measurable focus on Māori. % increase in earlier intervention of potential serious podiatry complications.

DHB activity	Milestone	Measure
partnerships of care between Māori whānau and providers; (c) promotion of wellbeing and the prevention of diabetes throughout life; (d) workforce development and training including competency in the management of diabetes and its complications in primary care and (e) community-based, culturally safe, coordinated models of care. The following targeted workstreams have recently commenced: Chronic Kidney Disease Programme Integrated podiatry care delivery (secondary and community services) Multidisciplinary and coordinated mobile diabetes screening and treatment service to improve access to care in rural, socially deprived areas Nurse Mentorship Program to improve the management of diabetes and its complications in general practice, focusing on high risk patients Development of the Northland diabetes workforce, including but not limited to, the appointment of Care Navigators and Kaiawhina. An additional pilot project is underway to explore the use of SmartPhone telehealth to improve opportunities for diabetes self-management.	delivery for people living with diabetes. Each activity includes an overarching focus on equity. Q1: Update Service Plans to ensure the successful implementation of the Diabetes Strategy priority activities. (See action 2 in 2.6.8 Improving quality and 2.5.6 Healthy food and drink environments for other relevant activities.) Q4: 12 month priority activity measures addressed.	% reduction in adverse outcomes (including incidences of high risk feet referrals, and lower extremity amputations). % increase the number of days prior to starting RRT from eGFR of < 30ml/min/1.73m² for Māori with diabetic nephropathy (see section 2.5.6). % improvement in HbA1c for people living with type 2 diabetes, using telehealth self-reporting technologies (see section 2.6.8).
2 Implement a population health outcomes performance framework and action plan in partnership with primary care with an overarching focus on the management of patients with diabetes, CVD and other long term conditions with a focus on achieving equity for Māori.	Q1: Draft framework and action plan developed. Q4: Framework and action plan implemented.	
3 Implement a new Green Prescription model which integrates with other active lifestyle funding streams that drive equitable delivery and the ongoing promotion of better self-management of health outcomes.	Q3: Draft integrated funding stream including an outcomes-based reporting framework developed. Q4: Integrated funding stream and outcomes-based reporting framework implemented.	
4 Northland continues to address our severe shortage of GPs and primary care workforce, which is driving some of our unfavourable statistics in hospital activity. Our investment in primary care workforce initiatives over the coming 12 months is expected to rebuild primary care		Measures for ASH ages 45-64.

DHB activity	Milestone	Measure
capacity and continue to improve activity in the community and reduce hospital activity.		
5 Northland DHB has offered agreements to 13 pharmacies across Northland to deliver a Hepatitis C Test and Treat in Pharmacy service, as part of a northern region initiative to detect and treat Hepatitis C in the community. This is a pilot project which is currently funded until 31 Dec. The aim of the project is to conduct a total of 1900 tests through pharmacies across the northern region in 2021, and find and treat 75 people who are RNA positive for Hepatitis C.	Q2: reporting to 31 Oct will inform the possible extension of the pilot.	

2.7.4 Reconfiguration of the National Air Ambulance Service Project – Phase Two

DHB activity	Milestone	Measure
1 Engage in multi-agency cross functional contingency planning for accessing remote areas of Northland under various conditions (that is, Covid-19 restrictions, weather events etc). SOP agreed by all agencies, and resourced adequately.	SOP agreed by all agencies, and resourced adequately.	Reduction in the number of transfers, from rural locations, not completed due to weather and/or other factors
2 Wider stakeholder group to develop a deeper understanding of inter-hospital transfers (by all modes) in preparation for Phase Two of the National Air Ambulance Service Project. To be achieved by engaging in cross-functional meetings and activities such as training days.	Increased collaboration across services and the wider DHB in respect to inter-hospital transfers. Northland DHB able to contribute meaningfully to Phase Two of the Project	

2.8 Financial performance summary

Statement of Comprehensive Income ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
DHB Provider Revenue	416,791	464,016	491,259	503,540	516,129	529,032
DHB Funder Revenue	308,817	321,411	352,020	360,821	369,841	379,087
DHB Governance & Administration	(0)	(0)	(0)	(0)	(0)	(0)
Inter District Flow Revenue	12,616	11,148	12,937	13,260	13,592	13,931
Total Revenue	738,224	796,575	856,216	877,621	899,562	922,051
DHB Provider Operating Expenditure	418,229	446,663	481,251	490,877	500,694	510,708
DHB Non Provider Funded Services	231,468	231,574	258,540	261,402	264,263	267,123
DHB Governance & Administration	494	326	384	392	400	408
Inter District Flow Expense	85,272	96,655	105,919	108,038	110,199	112,402
Total Operating Expenditure	735,463	775,217	846,095	860,708	875,556	890,641
Earnings before Interest, Depreciation, Abnormals & Capital Charge	2,760	21,358	10,121	16,913	24,006	31,409
Less						
Interest on Term Debt	507	430	117	120	122	125
Depreciation	14,999	15,575	22,700	23,154	23,617	24,089
Net Operating Surplus (Deficit)	(12,746)	5,353	(12,696)	(6,361)	267	7,195
Capital Charge	8,261	6,353	7,101	7,243	7,388	7,536
Surplus (Deficit)	**(21,007)**	**(1,000)**	**(19,798)**	**(13,604)**	**(7,121)**	**(341)**
Revaluation of Fixed Assets	0	0	0	0	0	0
Comprehensive Income	**(21,007)**	**(1,000)**	**(19,798)**	**(13,604)**	**(7,121)**	**(341)**

Statement of Movements in Equity ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
Equity at the beginning of the period	141,433	128,265	148,078	153,427	201,121	236,199
Surplus/Deficit for the period	(21,007)	(1,000)	(19,798)	(13,604)	(7,121)	(341)
Total Recognised Revenues and Expenses	120,426	127,264	128,280	139,824	193,999	235,859
Other Movements						
Revaluation of Fixed Assets	0	0	0	0	0	0
Other	(11)	0	0	0	(0)	0
Equity introduced (Repaid)	7,850	20,813	25,147	61,297	42,200	14,350
Equity at end of Period	**128,265**	**148,078**	**153,427**	**201,121**	**236,199**	**250,209**

Statement of Financial Position (000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
Equity						
Crown Equity	71,605	79,455	100,268	125,416	186,713	228,913
Retained Earnings	(54,137)	(55,138)	(74,936)	(88,539)	(95,662)	(96,002)
Subsidiaries & unrestricted trusts	203	203	204	204	204	204
Revaluation Reserve	102,743	102,744	102,744	102,744	102,744	102,744
Equity Injections	7,850	20,813	25,147	61,297	42,200	14,350
Total Equity	128,264	148,078	153,427	201,121	236,199	250,209
Represented by:						
Assets						
Current Assets	31,332	38,988	39,291	39,291	39,291	39,291
Non-Current Assets	243,244	265,042	289,092	346,532	388,775	395,740
Total Assets	274,576	304,030	328,383	385,823	428,067	435,031
Liabilities						
Current Liabilities	126,555	136,597	156,027	165,882	173,047	166,002
Non-Current Liabilities	19,757	19,354	18,928	18,820	18,820	18,820
Total Liabilities	146,312	155,952	174,955	184,702	191,867	184,822
Net Assets	**128,264**	**148,078**	**153,428**	**201,121**	**236,199**	**250,209**

Statement of Cash Flows ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
Cash Flows from Operating Activities						
Operating Income	743,933	797,289	856,032	877,554	899,493	921,980
Operating Expenditure	727,479	784,969	852,363	854,807	885,162	900,440
Net Cash from Operating Activities	16,453	12,319	3,668	22,747	14,331	21,540
Cash Flows from Investing Activities						
Interest receipts 3rd Party	409	168	149	123	126	129
Sale of Fixed Assets	22	10	(0)	0	0	0
Purchase of Fixed Assets	(20,836)	(33,833)	(43,750)	(79,094)	(63,700)	(28,850)
(Increase)/Decrease in Investments and Restricted & Trust Funds As	(749)	(3,545)	(3,000)	(1,500)	-	-
Net Cash from Investing Activities	(21,153)	(37,201)	(46,601)	(80,471)	(63,574)	(28,721)
Cash Flows from Financing Activities						
Equity injections (repayments)	7,850	20,813	25,147	61,297	42,200	14,350
Borrowings introduced (repaid)	(462)	(6,224)	(532)	(108)	-	-
Interest Paid	(507)	(430)	(117)	(120)	(122)	(125)
Other Non-Current Liability Movement	0	0	0	0	0	0
Net Cash from Financing Activities	6,881	14,160	24,497	61,069	42,078	14,225
Net Increase/(Decrease) in Cash held	2,181	(10,722)	(18,435)	3,345	(7,165)	7,045
Add opening cash balance	2,914	5,166	(5,556)	(23,991)	(20,646)	(27,811)
Closing Cash Balance	5,095	(5,556)	(23,991)	(20,646)	(27,811)	(20,766)

Consolidated Statement of Financial Performance ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
MOH Devolved Funding	695,011	751,235	813,282	833,614	854,454	875,816
MOH Non-Devolved Contracts (provider arm side contracts)	15,861	19,382	16,210	16,615	17,030	17,456
Other Government (not MoH or other DHBs)	8,190	8,745	8,473	8,685	8,902	9,125
Patient / Consumer sourced	548	381	497	509	522	535
Other Income	4,786	4,382	3,588	3,678	3,770	3,864
IDFs - All Other (excluding Mental Health)	12,616	11,148	12,937	13,260	13,592	13,931
InterProvider Revenue (Other DHBs)	1,213	1,300	1,229	1,260	1,291	1,323
Total Consolidated Revenue	738,224	796,575	856,216	877,621	899,562	922,051
Personnel Costs	286,765	300,781	323,802	330,278	336,884	343,621
Outsourced Services	45,336	51,663	49,082	50,064	51,065	52,087
Clinical Supplies	54,153	58,398	68,956	76,671	78,204	79,768
Infrastructure & Non-Clinical Supplies	32,468	36,146	39,795	34,255	34,940	35,639
Finance Costs	8,768	6,783	7,219	7,363	7,510	7,661
Depreciation	14,999	15,575	22,700	23,154	23,617	24,089
Personal Health	201,261	209,556	236,106	238,815	241,528	244,244
Mental Health	18,937	21,165	23,293	23,521	23,749	23,975
Disability Support Services	83,412	88,760	93,545	95,370	97,231	99,128
Public Health	6,249	529	663	672	682	691
Maori Health	6,881	8,219	10,853	11,061	11,272	11,488
Total Operating Expenditure	759,231	797,575	876,013	891,225	906,683	922,391
Surplus (Deficit)	**(21,007)**	**(1,001)**	**(19,798)**	**(13,604)**	**(7,121)**	**(341)**

Provider Statement of Financial Performance ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
MOH Non-Devolved Contracts (provider arm side contracts)	15,861	19,382	16,210	16,615	17,030	17,456
Other Government (not MoH or other DHBs)	8,190	8,703	8,004	8,204	8,409	8,619
Non-Government & Crown Agency Sourced	5,334	4,763	4,085	4,187	4,292	4,399
InterProvider Revenue (Other DHBs)	1,213	1,300	1,229	1,260	1,291	1,323
Internal Revenue (DHB Fund to DHB Provider)	386,194	429,866	461,731	473,274	485,106	497,234
Total Provider Revenue	416,791	464,016	491,259	503,540	516,129	529,032
Personnel Costs	286,765	300,781	323,802	330,278	336,884	343,621
Outsourced Services	45,336	51,663	49,082	50,064	51,065	52,087
Clinical Supplies	54,153	58,398	68,956	76,671	78,204	79,768
Infrastructure & Non-Clinical Supplies	31,975	35,821	39,411	33,864	34,541	35,232
Finance Costs	8,768	6,783	7,219	7,363	7,510	7,661
Depreciation	14,999	15,575	22,700	23,154	23,617	24,089
Total Operating Expenditure	441,997	469,021	511,170	521,394	531,821	542,458
Surplus (Deficit)	**(25,206)**	**(5,005)**	**(19,912)**	**(17,854)**	**(15,693)**	**(13,426)**

Governance Statement of Financial Performance ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
Government & Crown Agency Sourced	0	(0)	(0)	(0)	(0)	(0)
Total Governance Revenue	0	(0)	(0)	(0)	(0)	(0)
Infrastructure & Non-Clinical Supplies	494	326	384	391	399	407
Total Operating Expenditure	494	326	384	391	399	407
Surplus (Deficit)	**(494)**	**(326)**	**(384)**	**(391)**	**(399)**	**(407)**

Funder Statement of Financial Performance ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-2024 Budget	2024-2025 Budget
MOH Devolved Funding	695,011	751,235	813,282	833,614	854,454	875,816
Inter District Flows	12,616	11,148	12,937	13,260	13,592	13,931
Total Funder Arm Revenue	707,626	762,425	826,688	847,355	868,539	890,253
Personal Health	534,659	581,643	638,660	651,433	664,462	677,751
Mental Health	63,899	67,692	70,714	72,128	73,571	75,042
Disability Support Services	90,273	97,343	102,634	104,686	106,780	108,916
Public Health	6,890	1,382	1,442	1,470	1,500	1,530
Maori Health	7,213	10,034	12,741	12,996	13,256	13,521
Total Operating Expenditure	702,934	758,095	826,190	842,714	859,568	876,760
Surplus (Deficit)	**4,692**	**4,330**	**498**	**4,641**	**8,971**	**13,493**

Key Financial Analysis and Banking Covenants ($000s)	2019-20 Audited Actual	2020-21 Forecast	2021-22 Budget	2022-23 Budget	2023-24 Budget
Financial Analysis					
Term Liabilities and Current Liabilities	146,312	155,952	174,955	184,702	191,867
Debt	8,633	2,409	1,876	1,768	1,768
Owners Funds	128,264	148,078	153,428	201,121	236,199
Total Assets	274,576	304,030	328,383	385,823	428,067
Owners Funds to Total Assets	47%	49%	47%	52%	55%
Interest Expense	507	430	117	120	122
Depreciation Expense	14,999	15,575	22,700	23,154	23,617
Surplus/(Deficit)	(21,007)	(1,000)	(19,798)	(13,604)	(7,121)
Interest Cover	(11)	35	26	81	136
Debt/Debt + Equity Ratio	6%	2%	1%	1%	1%
Banking Covenants					
Debt/Debt + Equity Ratio	6%	2%	1%	1%	1%
Interest Cover	(11)	35	26	81	136
Interest Cover Minimum	3.0	3.0	3.0	3.0	3.0

3 Service configuration

3.1 Service coverage

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

3.2 Service change

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

At the moment there are no major service changes planned for 2021/22. Northland DHB is not intending to make any service changes as a result of our response to Covid-19. While we have reviewed our Covid-19 processes to refine and improve them, we are not planning on initiating any formal reviews.

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

Extra FTEs

Key initiatives over 2021/22:

Initiative	FTE
Whangarei Theatre Expansion	45
Assessment Unit	43
Rural hospitals (incl. Kaitaia Theatre)	30
Safe staffing CCDM	20
Acute Stroke Unit	13
Māori health	10
Child health	7
Safe after-hours	4
Diabetes	3
Renal	2
Total	177

3.3 Ability to enter into service agreements

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

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

4 Stewardship

4.1 Managing our business

4.1.1 Organisational performance management

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

Northland DHB will revisit our ELT dashboard alongside development of measures for Northland's health Strategy.

Processes for specific areas of operation are described in more detail in 4.1.2 to 4.1.4.

4.1.2 Funding and financial management

Key high-level figures/assumptions

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

Internally:

- our financial and 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
- financial reports and reviews occur at the Board's Equity with Resources, and at Board meetings
- delegated authorities are reviewed 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 agencies healthAlliance and HealthSource
- healthAlliance provides regional oversight of information systems and technology, and HealthSource was established regionally to maximise efficiencies in financial, supply chain and procurement functions.

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

4.1.3 Investment and asset management

Northland DHB is a Tier 2 Intensive Investment Agency under Treasury's Investment Management and Asset Performance (IMAP) with a Cabinet-approved Investor Confidence Rating of 'C' based on the assessment undertaken in 2016. The rating reflects Northland DHB's ability to manage investment portfolios and to successfully deliver promised benefits in the medium and long term. Northland DHB was not assessed in the 2020 northern region ICR assessment however we continue to improve our internal processes, attaining the benefits ICR processes can deliver. Northland DHB completed:

The Northland DHB Asset Management Strategy, Policy and Plan during the 2021 financial year and gained NDHB board approval. The documents are aligned with IIMM international standards and Northern Region Asset Management Strategy and Policy.

Established structured processes and resource capability for prioritisation and project management of major and minor capital works and clinical equipment projects.

Developed procurement capability, leveraging the expertise that the project team has developed in procurement of construction projects and fit out for business as usual projects, appointing evaluation panels supplemented by specialist advisors as required.

Advanced internal business case writing expertise.

Expanded facilities and risk management capabilities.

Northland DHB participates in Regional Capital Investment Group (RCIG) which is responsible for:

Driving capital planning and system process improvements.

Oversight of Facilities, infrastructure and clinical equipment planning and delivery processes and capacity and capability to implement and deliver approved work.

The Asset Management Planning subgroup has completed the Northern Region and National Asset Management Policy and Strategy. The group and is currently working on lifting asset management Northern Region capability across levels of service and data standardisation and developing asset management frameworks in response to the Health and Disability review and consolidation of DHB's under a single entity.

Northland's long term intentions include the redevelopment of the Whangarei Hospital campus and the Northland DHB strategy and strategic plan covering equity and access across primary and secondary services.

4.1.4 Shared service arrangements and ownership interests

The Northland DHB group consists of the parent, Northland DHB, and Kaipara Joint Venture Trust (54% ownership by Northland DHB). Northland DHB has a joint venture with the other Northern Region DHBs in healthAlliance NZ Limited (25%) and HealthSource (10%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

4.1.5 Risk management

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

The governance of risk is managed in the following way:

- a clear risk policy that all staff are made aware of
- a guide for staff on how to appropriately identify and manage risks
- monthly review of the high to extreme risks in Datix
- a monthly Risk Committee meeting to review the top risks and identify management plans where necessary
- monthly reporting to the Operational Management Group
  - https://www.fmhs.auckland.ac.nz/en/soph/about/our-departments/epidemiology-and-biostatistics/research/hgd/research-themes/imd/maps.html monthly reporting to the Finance, Risk and Audit Committee.

4.1.6 Quality assurance and improvement

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

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

4.2 Building capability

4.2.1 Capital and infrastructure development

Note that the Northern Region Capital Roadmap is still being developed in 2021.

Northland DHB is currently revising the Whangarei Hospital master plan and Northland DHB Clinical Services Plan to support the submission mid 2020 of a programme business case for a major redevelopment of Whangārei Hospital.. The aim of the redevelopment will be to transform health services in Northland with a focus on service, meeting demand and campus redesign. Whangarei Hospital campus interim projects include an Endoscopy Theatre which went live in April 2021 and a Cardiac Cath Lab which was operational in May 2021. The additional Theatre Capacity project will be complete and operational in July 2021

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

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

The infrastructure project team is working on stage two of the Bay of Islands Hospital redevelopment which will provide additional outpatient clinics, renal treatment and an oncology service. The addition of new primary health services will improve access and integration with onsite hospital services. The design has been tendered via the open competitive market, resulting in a preferred contractor being identified. The Ministry has approved $14.055M for the Bay of Island stage 2 build.

The Kaitaia site master plan is almost complete. The work will inform the work required to address weather tightness and condition issues following $10M prioritisation in the recent infrastructure fund.

Northland DHB allocates budget to baseline Facilities Minor Works and Clinical Equipment in the Annual Plan. Annual capital bid approval processes see bids assessed and prioritised by capital planning and review committees. This informs the makeup of the clinical equipment and buildings baseline capital funding allocation.

Of the clinical equipment budget, 20% is set aside as breakdowns to ensure there is immediate funding available to replace clinical equipment which breaks down during the year. The fund also covers the scenario where the cost of equipment repair is no longer viable or the equipment cannot be repaired. Large Clinical Equipment projects completed in 2020/21 include replacement of the three xray rooms in Whangarei, the full replacement of the Radiology ultrasound fleet and the

replacement of the aging washers and sterilisers in Whangarei and Kaitaia theatre sterilisation units.

Large Facilities Minor Works projects addressed in 2020/21 include the $3.5M power upgrade which will be completed in 2021/22.

4.2.2 Information technology and communications systems

Northland District Health Board continues to develop its capability in Information Technology and Communications. We are building on the success of the Health Record Transformation Programme, with a focus now on:

- extending planning and delivery capability across the whole Digital portfolio
- building clinical leadership capacity
- balancing the investment portfolio across risk, asset maintenance, new investments and transformation
- sustaining a clear emphasis on equity and care closer to home
- building clinical functional support capacity
- tight alignment with the regional ISSP.

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

Strengthening our ICT foundations. The scope of this includes moving our infrastructure to the all-of-government private cloud datacentres, developing a robust telecommunications and network capability, making it easier for providers and consumers to access the data and systems available (identity and access management), moving to Windows 10/ Office 365, and developing our hybrid cloud approach and capability. A significant thrust of this portfolio is to mitigate the risks associated with technology debt while allowing a focus on building for the future.

Simplify our layers of applications. Within this investment stream, the goal is to standardise on a small number of core systems, fill in some core functional gaps and progressively phase out the many hundreds of small applications that make up our complex IS landscape and constrain the way the system works. A number of major applications projects are underway which will provide platforms that will enable application consolidation and rationalisation to occur, such as the Regional Community Collaborative Care (RCCC) and Hospital Administration Replacement Project (HARP) which will enable access of key health information to consumers. While initial implementations of these systems are local to a DHB, the intent is for these to be regional.

Become experts at interoperability. We will grow our capability through embedding the MuleSoft Application programme interface (API) capability, and beginning the design of our regional data sharing and health information platform. The Data Sharing and Interoperability project is implementing several key aspects of the strategy including a Health Provider Directory.

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

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

- consumers/ whānau/ patients are the centre of our health system and they "share us/ their providers"
- consumers can see all their health information in one place/ application (a single portal) and interact with their providers with seamless processes to allow collaborative, coordinated care

- providers “share patients”; we work together to support and care for our patients by sharing information, communicating with each other and our patients with processes that are transparent, shared and person-centred
- we provide self-management resources, patient decision support pathways and wherever possible enable patients/ whānau to look after their own wellbeing.

The ISSP has been reviewed to ensure a tight alignment with the direction of the Health System Review.

4.2.3 Workforce

Workplace Health, safety and wellbeing

Workplace health, safety and wellbeing continues to be an organisation priority. Using Safe365 (the nationally adopted health and safety management maturity assessment) Northland DHB will continuously measure and strengthen our workplace health and safety policies and practices. Key areas of focus include the protection of workers from Covid, employee fatigue and burnout, violence, and bullying and harassment.

Northland DHB will seek to retain Tertiary level accreditation in the ACC Partnership programme audit. Through improved internal reporting and the cascade of management objectives it is expected that workplace health and safety plans will be integrated into all service plans.

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

Organisational culture and workforce development

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

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

Leadership

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

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

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

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

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

- achieving equity

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

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

Māori workforce development

Northland DHB is committed to developing the Māori workforce across the organisation 2.6.13 Workforce. We will:

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

4.2.4 Cooperative developments

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

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

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

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

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

5 Performance measures

Performance measure		Expectation		
Improving child wellbeing				
CW01	Children caries free at 5 years of age	Year 1	47.4% *(interim)*	
		Year 2	47.4% *(interim)*	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	0.92 *(interim)*	
		Year 2	0.92 *(interim)*	
CW03	Improving the number of children enrolled and accessing the Community Oral Health Service	Children (0-4) enrolled: ≥95% of preschool children (aged 0-4) will be enrolled in the COHS	Year 1	≥95%
			Year 2	≥95%
		Children (0-12) not examined according to planned recall: ≤10% of preschool and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1	> or = 85%	
		Year 2	> or = 85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	*Eight-month-olds:* 95% fully immunised.		
		Five-year-olds: 95% have completed all age-appropriate immunisations due between birth and five year of age.		
		HPV vaccine: 75% of girls and boys fully immunised		
		Influenza immunisation: 75% of 65+ year olds immunised		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has: reached the 'total population' target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) delivered all the actions and milestones identified for the period in its annual plan achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Focus area 1 Youth SLAT: provide reports as required.		
		Focus area 2 School Based Health Services: provide reports as required.		
		Focus area 3 Youth Primary Mental Health services: refer to MH04		
Improving mental wellbeing				
MH01	Improving the health status of people with severe mental illness through improved access	Age 0-19 Māori Other Total		5.11% 4.34% 4.74%

Performance measure		Expectation
		Age 20-64 Māori 10.22% Other 4.17% Total 6.07% Age 65+ Māori 2.22% Other 1.83% Total 1.88%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan 95% of audited files meet accepted good practice.
MH03	Shorter waits for mental health services for under 25-year-olds.	Provide reports as specified
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is: within 5% variance (+/-) of planned volumes for services measured by FTE 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified.
Improving wellbeing through prevention		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.
Better population health outcomes supported by strong and equitable public health services		
SS01	Faster cancer treatment, 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
SS03	Ensuring delivery of Service Coverage	Provide reports as specified
SS04	Implementing the Healthy Ageing Strategy	Provide reports as specified
SS05	Ambulatory sensitive hospitalisations (ASH adult)	4,350 per 100,000 standardised
SS07	Planned Care Measures *(reporting by exception only)*	1: Planned Care Interventions — TBC ESPI 1 — 100% services report Yes (that more than 90% of referrals within

Performance measure		Expectation		
		2: Elective Service Patient Flow Indicators		the service are processed in 15 calendar days or less)
			ESPI 2	0% patients are waiting over four months for FSA
			ESPI 3	0% patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% patients are waiting over 120 days for treatment
			ESPI 8	100% patients were prioritised using an approved national or nationally recognised prioritisation tool
		3: Diagnostics waiting times	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		4: Ophthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		5: Cardiac Urgency Waiting Times	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		6: Acute Readmissions	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	11.7%
		7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by ethnicity (developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2021/22 year.	
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>1% and ≤3%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%

Performance measure		Expectation		
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 85% and less than 95%.
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment, 62 days	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified.		
SS13	Improved management for long term conditions (CVD, acute heart health, diabetes, and stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*.	
			Ascertainment: target 95-105% and no inequity	
			HbA1c<64mmols: target 60% and no inequity	
			No HbA1c result: target 7-8% and no inequity	
		Focus Area 3: Cardiovascular health	Provide reports as specified	
		Focus Area 4: Acute heart service	Indicator 1, door to cath: door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.	
			Indicator 2a, registry completion: >95% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and…	
			Indicator 2b: ≥ 99% within 3 months.	
			Indicator 3, ACS LVEF assessment: ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).	
			Indicator 4, composite Post ACS Secondary Prevention Medication Indicator in the absence of a documented contraindication/ intolerance – ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge:	
			Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes)	

Performance measure		Expectation	
			ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes) Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5, device registry completion: ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services: provide confirmation report according to the template provided	Indicator 1 ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)
			Indicator 3: Inpatient rehabilitation: 80% patients admitted with acute stroke are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less, 100% within 30 days or less	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system	
SS17	Delivery of Whānau Ora	Appropriate progress identified in all areas of the measure deliverable.	
Better population health outcomes supported by primary health care			
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95% or above	

Performance measure		Expectation
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.
Annual Plan		
Annual plan actions – status update reports		Provide reports as specified

Appendix 1 Statement of Performance Expectations

The Statement of Performance Expectations (SPE) tells our 'performance story', activities we carry out to improve the health of Northlanders and contribute to a better society. The SPE is required under the Crown Entities Act 2004 to enable the Office of the Auditor General to monitor Northland DHB's performance. The SPE together with sections 1, 2.8 and 4 of the Annual Plan comprises our Statement of Intent.

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

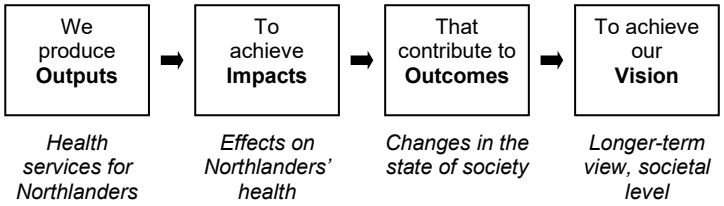
Output classes

Services are grouped into four output classes:

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

Intervention logic

The Statement of Performance Expectations is structured according to the following intervention logic (see table on the next page).



Impacts contribute to Outcomes, and together they contribute to High-level Outcomes. For example:

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

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

Note: Last year it was hoped that the 2021/22 SPE would incorporate measures from Northland's new health strategy, but it is not as far advanced as was expected at the time.

Summary of Statement of Performance Expectations 2021/22

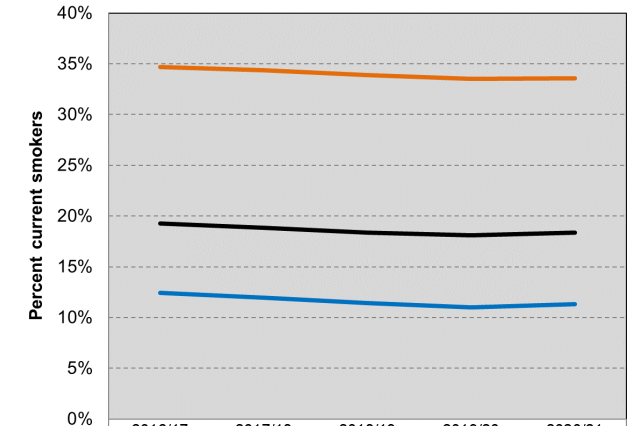
All measures by Māori and non-Māori where data is available.

Vision	A healthier Northland								
High-level Outcomes	Population health: improved health of Northlanders and reduced health inequities	Patient experience: patients and whānau experience clinically and culturally safe, good quality, effective, efficient and timely care				Value and sustainability: the Northland health system lives within available funding by improving productivity and prioritising resources to their most cost-effective uses			
High-level Measures	Life expectancy gap between Māori and non-Māori ↓ by 2 years	↓ gaps between: (a) Māori and non-Māori; (b) Northland and NZ	↓ mortality rate (age-standardised)	↓ infant mortality		Unplanned hospital admissions for Northlanders are reduced by 2,000 by 2017		>95% of patients report they would recommend the service provided	
Outcomes	Healthy population	Prevention of illness and disease		Reversal of acute conditions		Optimum quality of life for those with long term conditions		Independence for those with impairments or disability support needs	
Impacts	**Smoking cessation** Lower prevalence of smoking-related conditions	**Healthy children** Children are healthy from birth and have a healthy foundation for adulthood	**Effective primary care** People manage in the community through effective primary care services	**Long term conditions** Amelioration of disease symptoms and/or delay in their onset	**Cancer** If curable, increased likelihood of survival; if incurable, reduced severity of symptoms	**Mental disorders** Acute episodes are minimised, clients achieve greater stability, and quality of life is improved for both clients and their families	**ED waiting times** More timely assessment, referral and treatment	**Quality and safety** More satisfied patients Fewer adverse clinical events Lower rates of acute readmission to hospital	**Support for older people** Older people requiring support or care receive services appropriate to their needs.
Impact Measures	% adults who are current smokers % pregnant women who identify as smokers on registration with a midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Full and exclusive breastfeeding at 3 months % 8-month-olds who have their primary course of immunisation on time Average number of decayed, missing or filled teeth in Y8 students % 4-year-olds identified as obese in B4 School Checks will be offered a referral to a health professional	Ambulatory sensitive hospitalisation ages 0-4, rate/100,000, unstandardised	% diabetics receiving annual free checks who have good blood sugar management % eligible people receiving cardiovascular risk assessment in the last 5 years	Breast cancer screening in eligible populations Cervical cancer screening in eligible populations % patients who receive first cancer treatment (or other management) within 62 days referred urgently with a high suspicion of cancer and a need to be seen within two weeks	% people with enduring mental illness aged 20-64 who are seen over a year	% patients admitted, discharged or transferred from and ED within 6 hours	% older patients assessed for risk of falling; those at risk who have individualised care plans % of opportunities for hand hygiene taken Surgical site infections per 100 hip and knee operations where antibiotic is given 0-60 mins before 'knife to skin' Patient deterioration: % patients with early warning scores calculated correctly; % patients who triggered an escalation of care and received the appropriate response	Home and Community Support Services (HCSS) clients assessed using interRAI tool HCSS providers certified ARRC providers with at least 3 years certification
Output Classes	**Prevention**		**Early detection and management**		**Intensive assessment and treatment**			**Rehabilitation and support**	
Outputs	Advice and help offered to smokers in primary care Advice and help offered to pregnant women Advice and help offered to smokers in hospital	Midwifery services by LMCs MIdwifery services by DHB Support by lactation consultants Oral health assessment and treatment Immunisations in primary care 4-year-olds given B4SC	Services provided in primary care Acute hospital services	Assessment, diagnosis and treatment in primary care	Screening for breast cancer Screening for cervical cancer Cancer risk assessments in primary care Provision of cancer treatment	Specialised clinical support by NDHB community mental health services Admission to hospital for those with acute mental illness	Assessments, treatments performed in EDs	Leadership, advice and monitoring by Quality Improvement Directorate Effective clinical services Patient pathways, hospital discharge processes	Home based support services Residential care Work with providers on corrective action plans resulting from audit
Output Measures	People attending primary care who have ever smoked	Hospital births Lactation consultant contacts Immunisations by 8 months Oral health treatments for Y8 students Visits by children and youth to primary care B4SC performed	Acute hospital discharges	Risk assessments and monitoring of people with diabetes and/or CVD	Screening for breast and cervical cancer Referrals for radiotherapy and chemotherapy treatments	Contacts by community mental health workers with people who have enduring mental illness	Emergency department attendances	Measures of the quality and safety of services	Assessments by NASC service Certification audits

Output Class 1: Prevention

Impact: Lower prevalence of smoking-related conditions.

Measure: % of adults who are current smokers



	2016/17	2017/18	2018/19	2019/20	2020/21
Total	19.3%	18.8%	18.3%	18.1%	18.3%
Maori	34.7%	34.4%	33.9%	33.5%	33.6%
Non-Maori	12.4%	11.9%	11.4%	11.0%	11.3%

Rationale

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

Currently 33.6% of Māori and 11.3% of non-Māori smoke. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025. Over the last five years the average annual decline in smoking rates has been 0.36% for non-Māori and 0.33% for Māori. To reach the 5% target the average annual reduction needs to be 1.6% for non-Māori and 7.1% for Māori.

This data comes from Northland's PHE and does not match with NZ Health Survey data, but it is preferred for this purpose because it is produced quarterly so it permits more regular monitoring.

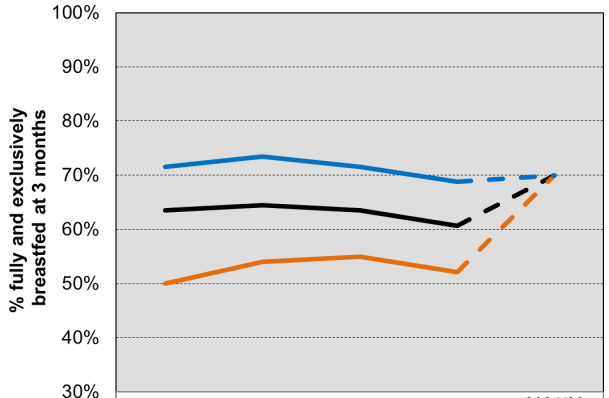
Outputs

Primary care records show 25,241 current smokers, of whom 14,588 are Māori and 10,653 non-Māori (2020/21 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



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	64%	65%	64%	61%	70%
Maori	50%	54%	55%	52%	70%
Non-Maori	72%	74%	72%	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 infant health should have a significant effect on improving the health of Māori over time.

Outputs

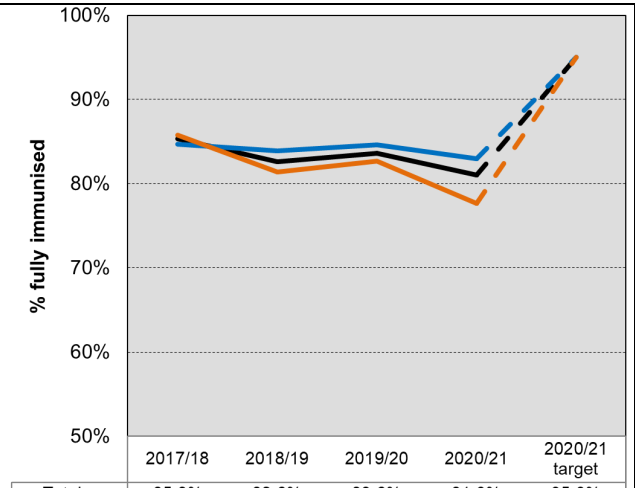
Total NDHB hospital births: 2,047 for the twelve months ending March 2021.

903 lactation consultant patient contacts for the twelve months ending March 2021.

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

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

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2020/21 target
Total	85.3%	82.6%	83.6%	81.0%	95.0%
Non-Maori	84.7%	83.9%	84.6%	83.0%	95.0%
Maori	85.8%	81.4%	82.7%	77.6%	95.0%

Rationale

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

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

In March 2021 the parents of 13% of Northland's 8-month-olds either declined to have their child immunised or opted off the National Immunisation Register. This is the second highest of any DHB and two-and-a-half times higher than the national figure. Various approaches are used to encouraging higher attendance rates and early enrolment in primary care will raise immunisation coverage.

Outputs

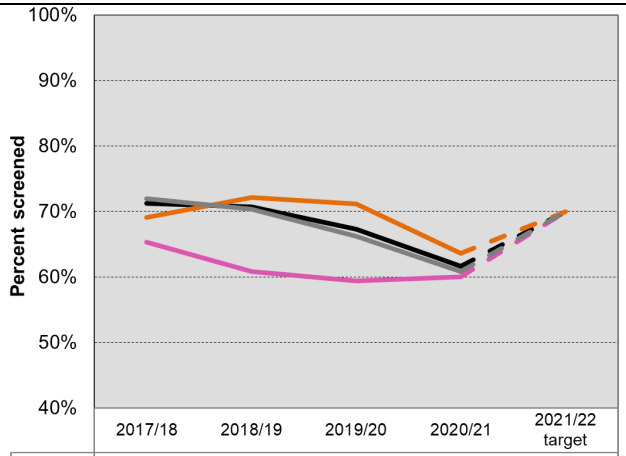
Out of 2,431 children eligible, 1,992 were fully immunised before 8 months of age during the twelve months ending Dec 2020.

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

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

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

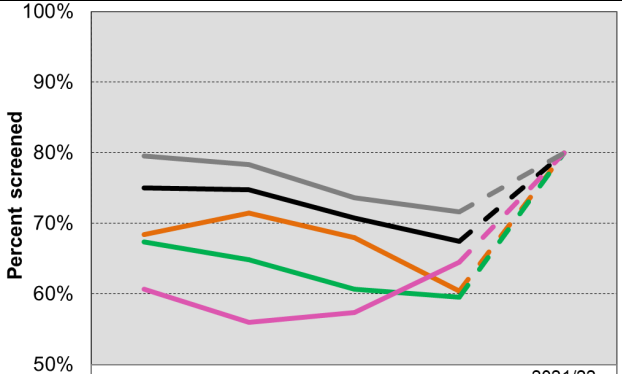
Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	71.3%	70.7%	67.3%	61.6%	70.0%
Maori	69.1%	72.2%	71.2%	63.6%	70.0%
Pacific	65.3%	60.9%	59.4%	60.1%	70.0%
Other	72.0%	70.4%	66.2%	60.9%	70.0%

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

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	75.0%	74.8%	70.8%	67.5%	80.0%
Maori	68.5%	71.4%	68.0%	60.4%	80.0%
Pacific	67.3%	64.8%	60.7%	59.5%	80.0%
Asian	60.7%	56.0%	57.3%	64.5%	80.0%
Other	79.5%	78.4%	73.6%	71.6%	80.0%

Rationale

Screening in the community to identify cancers as early as possible improves the chances of prevention or, if the condition already exists, recovery. Screening programmes have existed in New Zealand for many years for breast cancer and cervical cancer, and bowel cancer screening is currently being established (Northland's 'go-live' date is August 2021).

Outputs

20,735 eligible women were screened in year to March 2021, including 5,827 Māori, 289 Pacific and 14,619 other.

Outputs

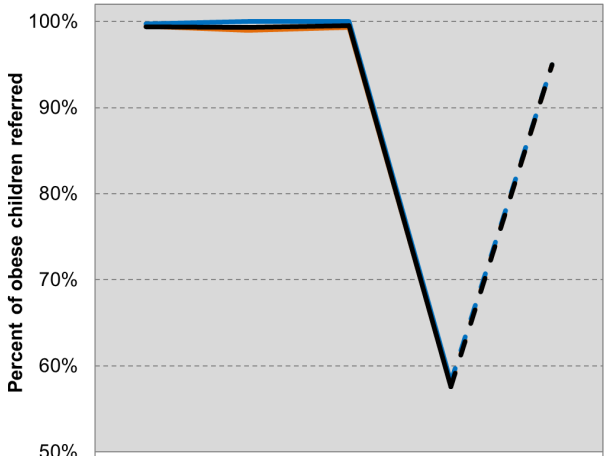
33,171 eligible women screened in the three years up to March 2021, of whom 9,506 Māori, 541 Pacific, 1,570 Asian, 21,554 other .

Output Class 2: Early Detection and Management

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

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

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Maori	99.4%	99.0%	99.3%	57.7%	95%
Non-Maori	99.8%	100.0%	100.0%	58.1%	95%
Total	99.4%	99.3%	99.5%	57.6%	95%

Rationale

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

In Northland, 48% of Māori are obese compared with 37% of non-Māori (2014-17 NZ Health Survey).

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

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

Other initiatives in Northland include:

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

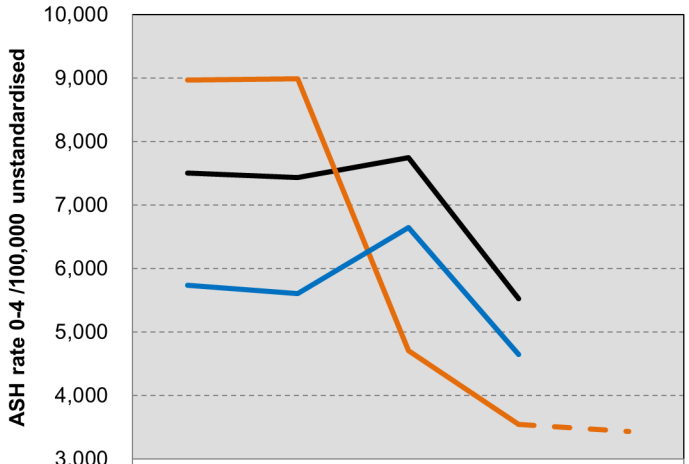
Outputs

4,028 4-year-olds checked March 2020-Feb 2021, of whom 1,391 Māori, 963 Pacific, 1,674 other.

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

Measure

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



	2017/18	2018/19	2019/20	2020/21	2020/21 target
Total	7,507	7,431	7,751	5,527	
Maori	8,966	8,995	4,704	3,547	3,440
Other	5,742	5,602	6,652	4,644	

Measure type
Quality

Rationale

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

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

Lowering ASH rates not only improves the health of patients, it also frees up specialist hospital resources for more acute and urgent cases, thus achieving better value for money from the health dollar. This requires managing the complex interface between primary and secondary care, for which NDHB has a number of initiatives in place or planned. For example, NDHB is trialling a Primary Options Acute Demand Management Service to enable GPs to flexibly develop management plans for their patients and thus avoid hospital admissions.

Outputs

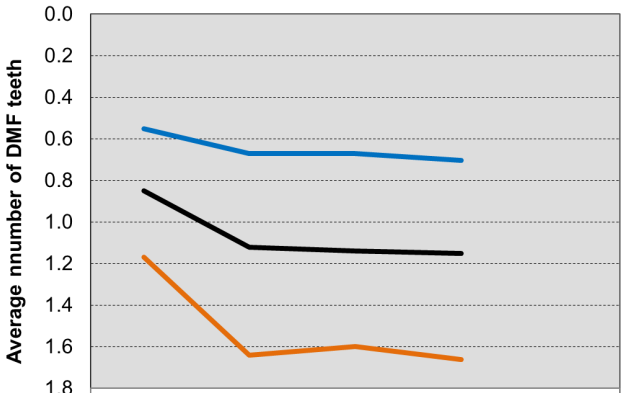
549 ASH discharges ages 0-4 year to March 2021, of whom 365 were Māori and 184 non-Māori.

The Māori-only target is based on the one in the SLM plan (appendix 1 in the Annual Plan 2021/22): "reduce ASH events for tamariki Māori by 5% (28) (based on Baseline of DEC 2019 (558) events".

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:



	2017	2018	2019	2020	2021 target
Total	0.85	1.12	1.14	1.15	
Maori	1.17	1.64	1.60	1.66	
Non-Maori	0.55	0.67	0.67	0.70	

Rationale

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

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

Northland will always struggle to reach the oral health status of DHBs that have fluoridated water supplies. Northland remains unfluoridated.

Outputs

889 Year 8 students were treated by NDHB's services in CY 2020.

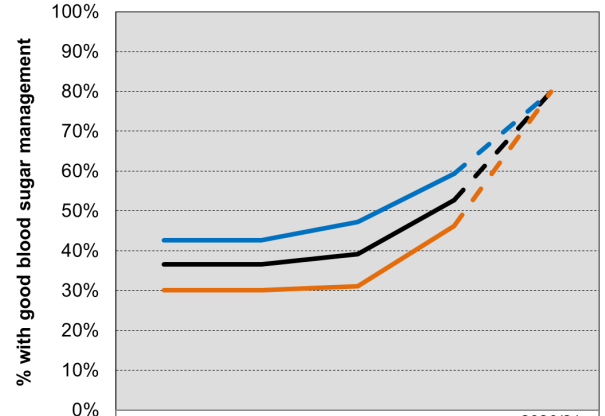
Values on the y axis have been reversed because the lower the performance on this measure the better.

A target for 2021 has yet to be agreed with MoH.

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

Measure: % of diabetics aged 15-74 who receive annual free checks whose most recent HbA1c (blood sugar level) during the past 12 months is equal to or less than 64 mmol/mol;

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2020/21 target
Total	36.5%	36.5%	39.2%	52.7%	80.0%
Maori	30.0%	30.0%	31.2%	46.2%	80.0%
Non-Maori	42.6%	42.6%	47.2%	59.4%	80.0%

Rationale

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

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

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

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

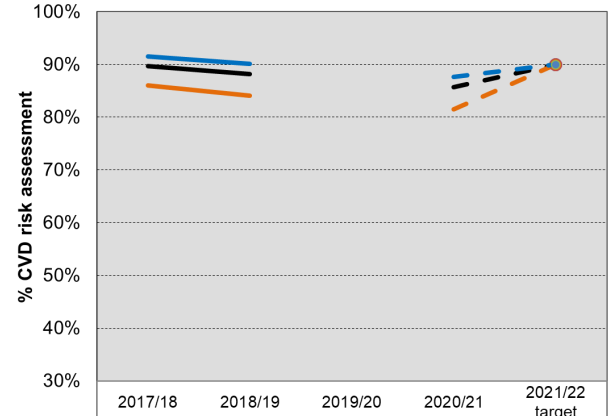
Outputs

As at March 2021 7,463 people aged 15-74 were on the Northland diabetes register, of whom 3,787 were Māori and 3,676 non-Māori.

The current preparation of a Diabetes Strategy for Northland has entailed establishing a more accurate idea of how many Northlanders have diabetes. The current estimate is 11,106, which tallies closely with the 11,625 in the Ministry's Virtual Diabetes Register (their estimate based on a theoretical model). This assumes conservatively a diabetes prevalence of 6% (the national average), in the 10,355 unscreened Mahitahi patients. However this may be as high as 10% because the non-engaged group are hard to reach and likely to have a higher prevalence, which would bring the total in line with the VDR.

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

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	89.7%	88.2%		85.7%	90.0%
Maori	86.0%	84.1%		81.5%	90.0%
Non-Maori	91.5%	90.1%		87.7%	90.0%

Rationale

Along with cancer, cardiovascular (heart and circulatory) disease is the most common long term condition.

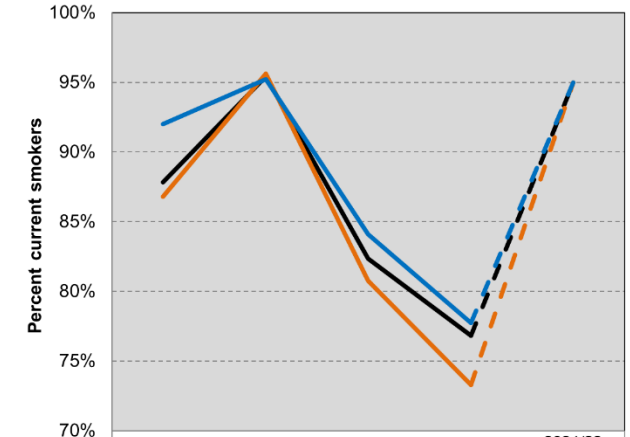
Prevalence of CVD conditions is higher among Māori. It also increases with age, so the ageing population means we need to carefully monitor and control the incidence and severity of conditions.

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

Outputs

54,922 CVD risk assessments performed in primary care over the five years to March 2021, of whom 17,846 were the high-risk groups of Māori, Pacific or Indian, and 37,076 were other ethnicities.

MoH did not produce reliable, comparable data during 2019/20 because they were changing the way the data was counted. They have cautioned against using 2019/20 data in time trends.

Measure: % of pregnant women offered brief advice and support to quit smoking	**Rationale**	**Outputs**
	Smoking and obesity are the two most significant drivers of long term conditions. Smoking puts babies at higher risk of conditions such as glue ear, asthma, leukemia and Sudden Unexplained Death in Infancy (SUDI). Currently 33.3% of Māori and 11.0% of non-Māori smoke. New Zealand has committed to a goal of reducing smoking rates to 5% by 2025.	Primary care records show 118,588 Northlanders who have ever smoked, of whom 24,606 are current smokers (2020/21 Q3).

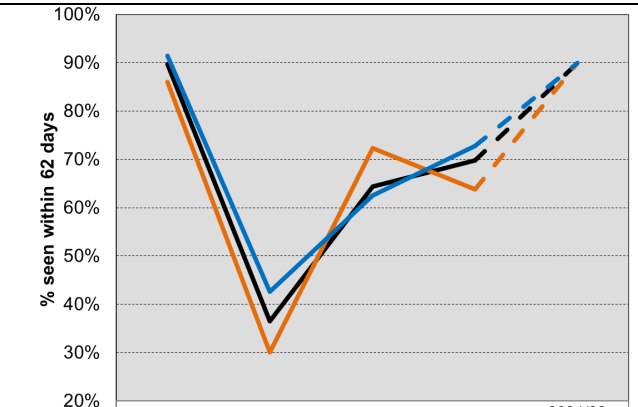
	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	87.8%	95.4%	82.3%	76.8%	95.0%
Maori	86.8%	95.6%	80.8%	73.3%	95.0%
Non-Maori	92.0%	95.2%	84.1%	77.7%	95.0%

Output Class 3: Intensive Assessment and Treatment

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

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

Measure type: Coverage



	2017/18	2018/19	2019/20	2020/21	2021/22 target
Total	89.7%	36.5%	64.3%	69.8%	90.0%
Maori	86.0%	30.0%	72.3%	63.8%	90.0%
Non-Maori	91.5%	42.6%	62.6%	72.7%	90.0%

Rationale

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

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

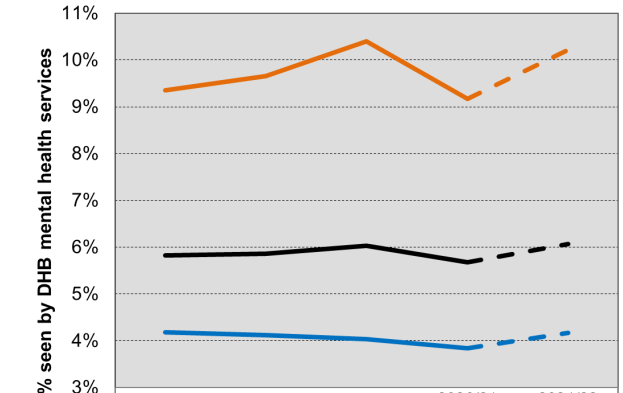
Outputs

334 patients referred urgently with high suspicion of cancer for the twelve months ending March 2021 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



	2017/18	2018/19	2019/20	2020/21 to Q2	2021/22 target
Total	5.83%	5.86%	6.03%	5.68%	6.07%
Maori	9.36%	9.65%	10.40%	9.17%	10.22%
Non-Maori	4.18%	4.12%	4.03%	3.84%	4.17%

Rationale

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

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

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

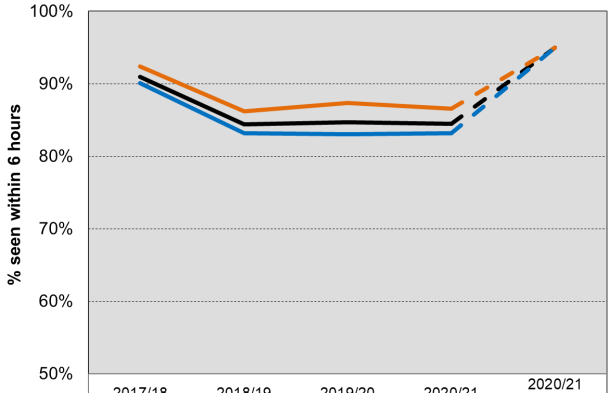
Outputs

5,773 clients aged 20-64 as at Dec 2020, of whom 3,206 Māori and 2,567 other.

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



	2017/18	2018/19	2019/20	2020/21	2020/21 target
Total	90.9%	84.4%	84.7%	84.5%	95.0%
Maori	92.4%	86.2%	87.3%	86.6%	95.0%
Non-Maori	90.1%	83.2%	83.1%	83.2%	95.0%

Rationale

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

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

Outputs

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

Emergency department attendances for CY 2020 44,179.

Impact: Fewer adverse clinical events.

Measures type: Quality

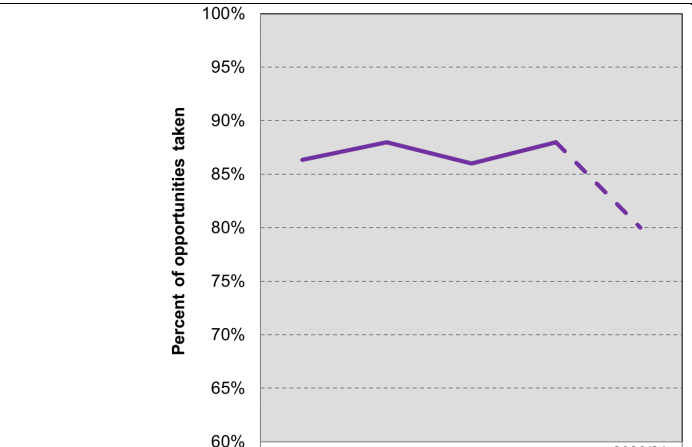
% older patients assessed for the risk of falling

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

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

	2017/18	2018/19	2019/20	2020/21	2020/21 target
% older patients assessed for the risk of falling	77%	52%	68%	69%	90%
% older patients assessed as at risk of falling who received an individualised care plan that addresses these risks	68%	75%	97%	94%	90%

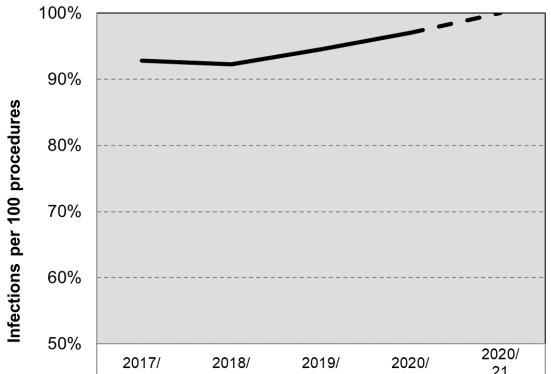
Percentage of opportunities for hand hygiene taken



	2017/18	2018/19	2019/20	2020/21	2020/21 target
% of hand hygiene opportunities taken	86.3%	88.0%	86.0%	88%	80.0%

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

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



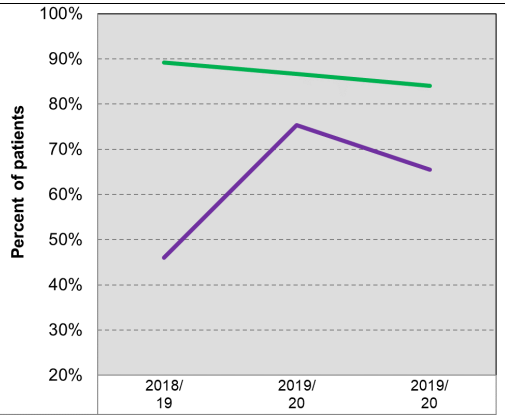
	2017/18	2018/19	2019/20	2020/21	2020/21 target
% of hip and knee arthroplasty primary procedures where antibiotic given 0–60 minutes before 'knife to skin'	92.8%	92.3%	94.5%	97%	100%

% of patients with early warning scores calculated correctly

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

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

A national target does not yet exist.



	2018/19	2019/20	2019/20
% of patients with early warning scores calculated correctly	0.89	0.87	0.84
% of patients who triggered an escalation of care and received the appropriate response	0.46	0.75	0.66

Rationale

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

The Health Quality and Safety Commission has developed nationally consistent Quality and Safety Markers. The data is from: https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/

Outputs

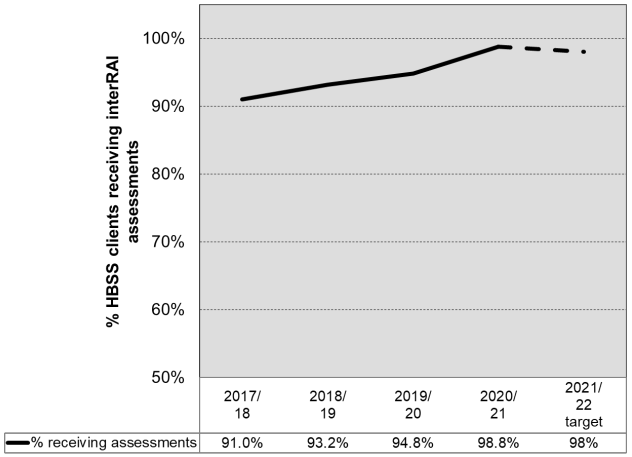
Advice and monitoring provided by the Quality and Improvement Directorate, which is overseen by the Chief Medical Officer.

Output Class 4: Rehabilitation and Support

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

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

Measure type: Coverage



Rationale

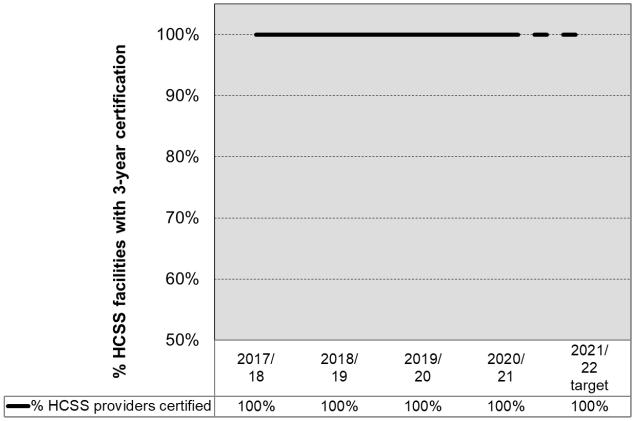
Good quality clinical assessment for older people who live at home helps them remain there. With the assistance of home and community support services they are more able to 'age in place' rather than enter supportive accommodation. This not only improves their quality of life but reduces pressure there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

Outputs

2,105 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 2020.

Measure: % of HCSS providers certified

Measure type: Quality



Rationale

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

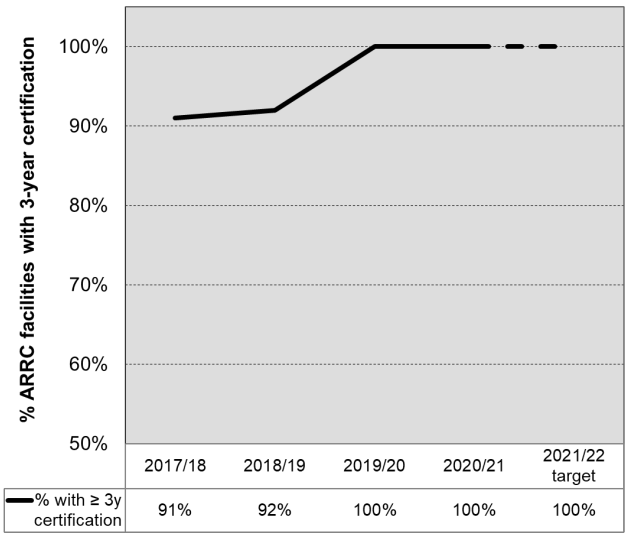
All NDHB home and community support services are certified, and Northland DHB ensures providers maintain their certification status.

Outputs

9 providers of home based support services, providing support to 2,620 people in the community up to Dec 2020.

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

Measure type: Quality



Rationale

Certification reduces potential risks to residents by ensuring providers comply with the Health and Disability Services Standards.

The period of certification for aged residential care providers reflects their risk level; the fewer the number and the lower the level of risks identified during audits, the longer the period of certification.

Outputs

Since 2010 a single audit process has encompassed DHB aged care contracts and MoH certification audits. DHBs on work with providers on corrective action plans to address any matters identified though the audits, monitor progress against the agreed corrective action plans, and manage risks that may arise.

In 2020/21 there are 24 facilities, of which 13 have 3-year certification and 10 have 4-year. One facility, which previously had 3 years certification, changed ownership in February 2021 and as a result has an automatic 1 year certification period. 23/24 = 96% of facilities have certification of 3 years or higher.

Statement of Financial Performance - By Output Class ($000s)

	2021-22 Budget
Output Class Revenue	
Intensive Assessment & Treatment	515,556
Early Detection & Management	179,873
Prevention	33,682
Rehabilitation & Support Services	127,104
Total SOI Revenue	**856,216**
Output Class Expenses	
Intensive Assessment & Treatment	516,566
Early Detection & Management	195,320
Prevention	32,776
Rehabilitation & Support Services	131,352
Total SOI Operating Expenditure	**876,013**
Surplus / (Deficit) by Output Class	
Intensive Assessment & Treatment	(1,010)
Early Detection & Management	(15,446)
Prevention	907
Rehabilitation & Support Services	(4,248)
Net Surplus / (Deficit)	**(19,798)**

Appendix 2 System Level Measures Improvement Plan 2020/21

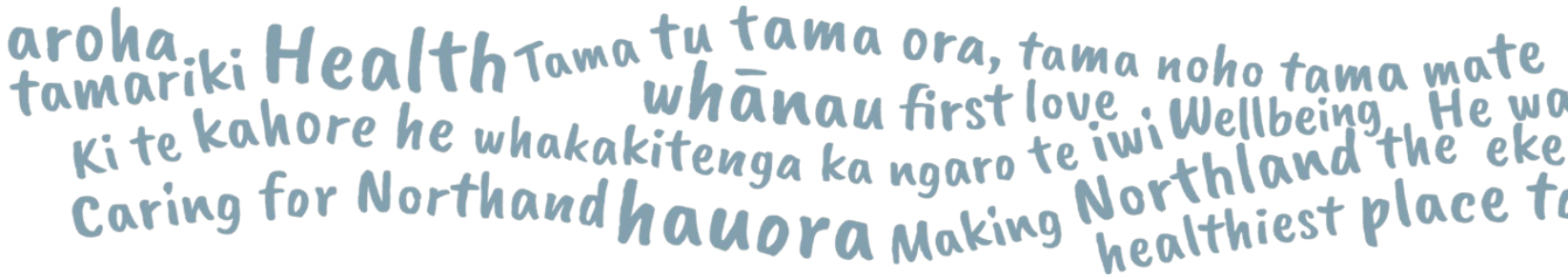
This SLM plan covers the requirements of the community part of 2.6.6 Acute demand and 2.7.1 Primary health care integration.

Mahitahi Hauora

NORTHLAND SYSTEM LEVEL MEASURES IMPROVEMENT PLAN 2021/22

Mahitahi Hauora

Contents



Introduction

In July 2019, a new and sole Primary Health Entity, Mahitahi Hauora, was launched in Northland. The Mahitahi Hauora Board members are drawn from Northland District Health Board (NDHB), Iwi and hapū, Māori Health Providers, General Practice, and our community. This collaborative approach supports the commitment and determination to deliver a transformational strategy for Northland primary healthcare. The Board of Mahitahi Hauora is a living embodiment of the Northland Alliance.

Geoff Milner (Chair)

Ngāti Porou/Ngāti Kahungunu

Chief Executive Officer, Ngati Hine Health Trust

Dr Suzanne Phillips

General Practitioner - Bayview Medical Centre Paihia

Marihi Langford

Chief Executive, Ngāti Kahu Social and Health Services

Moe Milne

Nurse, Officer of the New Zealand Order of Merit, Māori Mental Health Leader

Dr Taco Kistemaker

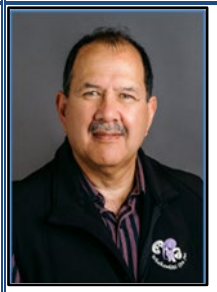
General Practitioner -Broadway Health

Lynette Merle Stewart CNZM

Ngātiwai-

Patuharakeke-Tainui

Chief Executive, Ki A Ora Ngātiwai



Errol Murray

Te Aupouri, Ngāti Kuri, Te Rarawa, Ngāti Kahu ki Whangaroa, Ngāi Takoto.

General Manager Whakawhiti Ora Pai. Representative for the Māori Health

Dr Justine Woodcock

GP Director Broadway Health

Kaikohe, Waipapa, Kaitaia

Boyd Broughton

(Ngā Puhi) Te Kau o Taonui

representative.

General Manager of iwi healthcare provider Te Hā Oranga.

Dr Nick Chamberlain (non-voting member of the Board) Chief Executive, Northland District Health Board

Background

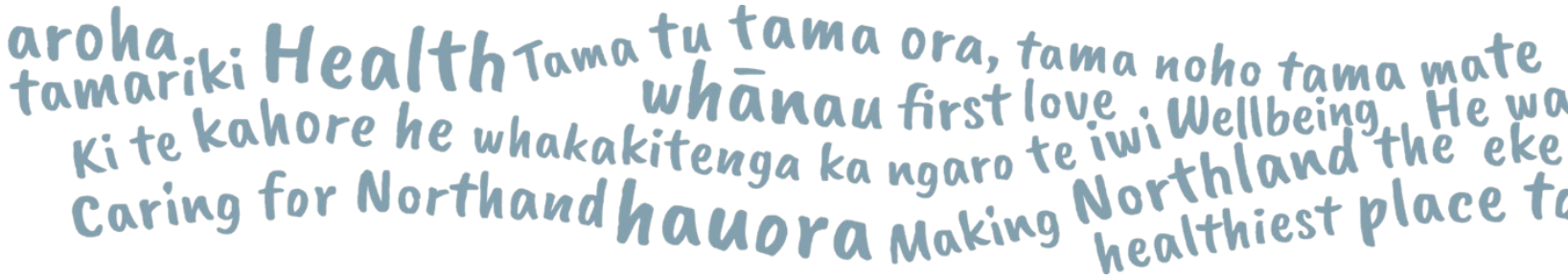
Development of the Mahitahi Hauora Strategy and Action Plan has required a different way of thinking and engaging with consumers, whānau, iwi, tertiary providers, and representatives from across primary, community and secondary care. This approach will be maintained through implementation and extended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

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

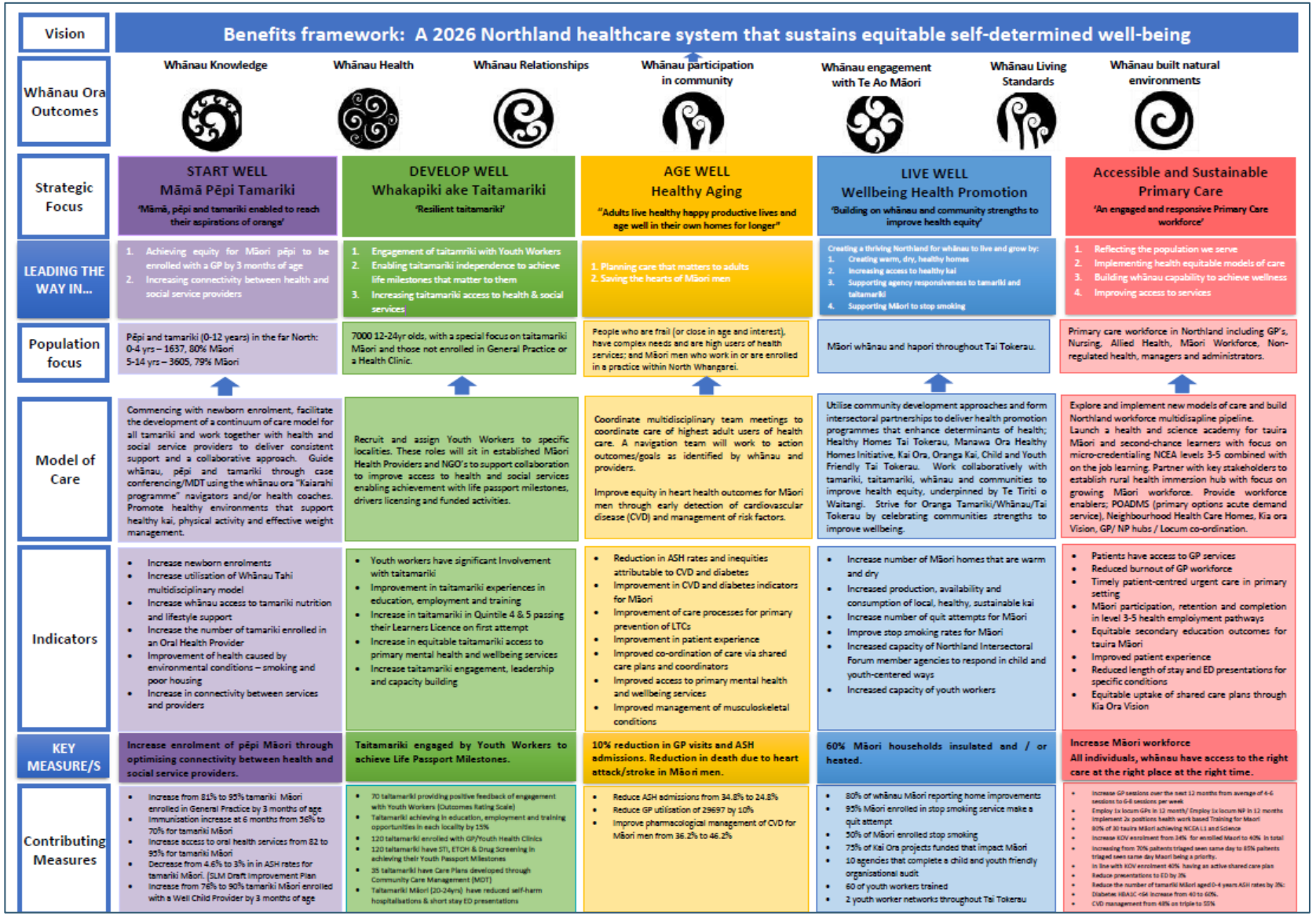
Appreciative Inquiry hui have been held across Tai Tokerau. The process is a strengths-based way of building upon the many good aspects that already exist in human systems. It seeks to engage stakeholders in self-determining change, and identify opportunities for collaboration, establishing trust, and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

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

1) A portfolio approach of three key priority areas:
    - Mama, Pēpi and Tamariki 0-11years: Start Well.
    - Taitamariki 12-24 years: Develop Well.
    - Healthy Aging: Long term conditions and complex conditions: Age Well.
2) To use localities to incubate ideas, models of care and achieve outcomes. Learning, continuous improvement and collaboration across providers from the locality mahi will be used to inform progress and ensure we are accountable to our aims and objectives.



Mahitahi Hauora



Mahitahi Hauora worked in partnership with iwi, Māori health providers, NDHB, and general practices to manaaki and support communities, whānau, hapū, and iwi during COVID-19 alert levels. We're focusing resources and prioritising the health needs of Māori in all our mahi, so they have equitable access to high quality care.

The impact of COVID-19 on primary care and those who deliver primary care cannot be underestimated. We worked hard to collaborate swiftly and with urgency to ensure our most vulnerable were protected, and those delivering our primary care were fully supported. They were extremely challenging times for us all, but we learnt some great lessons on the power of working together and listening to different points of view. Our main priority in responding to the pandemic was to support and protect the health of whānau and the community across Te Tai Tokerau, and our primary care services and workforce through our COVID-19 response team. COVID-19 , and funding impacts did suspend some planned activity for example, the establishment of a Hauora Academy for Northland.

SIGNATORIES

Jensen Webber
Acting CEO Mahitahi Hauora

Mahitahi Hauora

Dr Nick Chamberlain
CEO Northland District Health Board

NORTHLAND DISTRICT HEALTH BOARD
Te Pouri Hauora A Rohe O Te Tai Tokerau

Ambulatory Sensitive Hospitalisations for 0-4year olds SLM plan 2021/2022

Reduced avoidable hospital admissions among children

Current National Enrolment Service (NES) data illustrates an inequity for the rates of enrolment for Pēpi Māori compared to non-Māori. Stats as at December2020 (second quarter) and March 2021 (Third quarter) enrolments by Northland DHB.

	Total popn. % enrolled	% Māori
Stats as at December 2020 (second quarter):		
At 6 weeks of age	67.2%	61.9%
At 3 months of age	81.1%	71.8%

	Total popn. % enrolled	% Māori
Stats as at March 2021 (third quarter):		
At 6 weeks of age	68.5%	60.7%
At 3 months of age	84.6%	77.2%

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

Findings from engagement and data analysis identified:

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

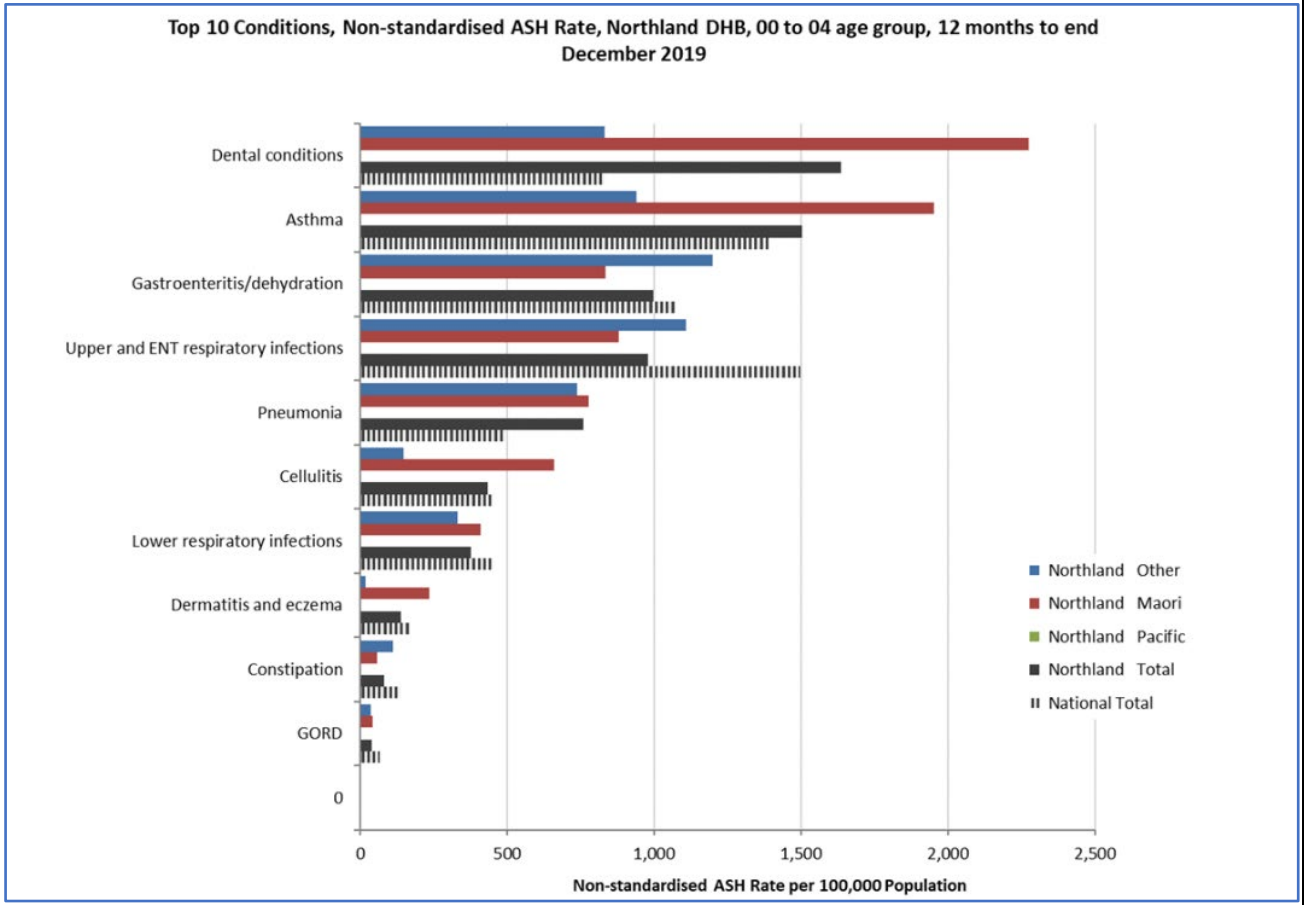
Mahitahi Hauora identified a high priority group of Pēpi, within the geographical locality of Kaikohe, Kawakawa, Whangaroa (Kaeo), Moerewa and Paihia *(Locality One) in 2019 which was the focus of the 2019/2020 action plan. A second Locality, Muriwhenua/Far North, is currently being rolled out.

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

Increased access to primary care will lead to:

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

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



Source: https://nsfl.health.govt.nz/system/files/documents/pages/si_1_-_report_-_data_to_2019q4_wiesnz14_-_v1.04.xlsm

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

Milestones	Activities	Contributory measures
Reduce ASH events for tamariki Māori by 5% (28) (based on Baseline of DEC 2019 (558)events	Implement a pilot project initially in Mahitahi Hauora Mid North Locality One * that prioritises those Tamariki Māori with notified recurrent admission with identified ASH conditions to refer for proactive case management, through existing MDT processes. Initiate the resourcing and planning for the implementation of two projects within the Locality for Mama, Pēpi, Tamariki as identified priorities * by Mahitahi Board, our Northland Alliance: • Start Well (Oral Health) Projects • Start Well (Growth) Projects • Map dental service registration through to enrolment • Determine gap analysis • Provide Health Coach to support the Navigation of services for whānau Tamariki will be enrolled under the Koira 4Rukahukahu: Lungs4Life programme	Number of Manawa Ora Healthy Home Initiative (HHI) referrals received and actioned for priority tamariki Number of tamariki Māori within our pilot Mid North Locality One * admitted to hospital with identified recurrent ASH admissions who are subsequently referred for MDT proactive case management Rate of Tamariki Māori receiving immunisations by 6 months of age Rate of Tamariki Māori receiving growth related interventions Rate of Tamariki Māori receiving appropriate dental care before starting school. • Number of pēpi enrolled in the dental service by 1 year of age (% Māori) • Number of pēpi who receive their first oral health appointment at by 14 months of age (% Māori) Reduced hospitalisation rate for bronchiectasis

Acute Bed Days SLM Plan for 2021/2022

Improved management of demand for acute care

Mahitahi Hauora

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

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

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

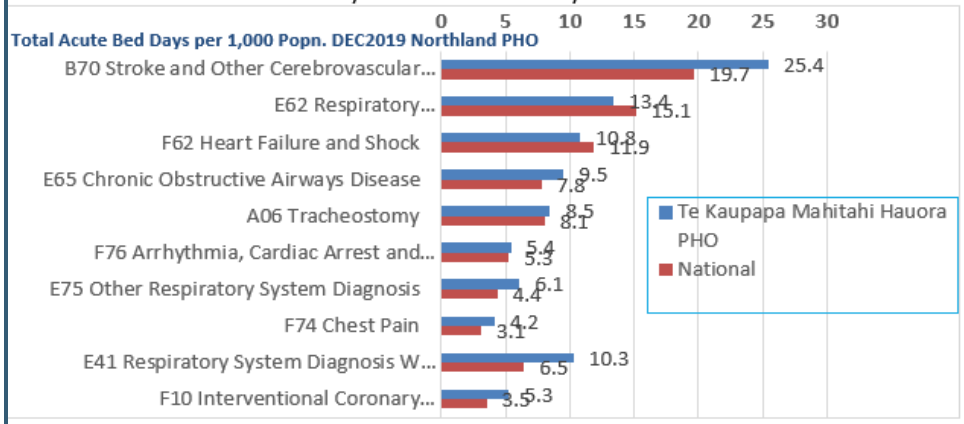
These challenges contribute to early death, increased system level demand through service usage, increased strain on physical and financial resources and poorer health outcomes and quality of life for these people. In addition, Appreciative Inquiry workshop findings have pointed to clinical stress and job dissatisfaction due to inability to fully meet the needs of complex patients. Northland is experiencing a significant increase in population. Coupled with our aging workforce and ever-increasing demand on access of health services, it is putting the system under significant strain:

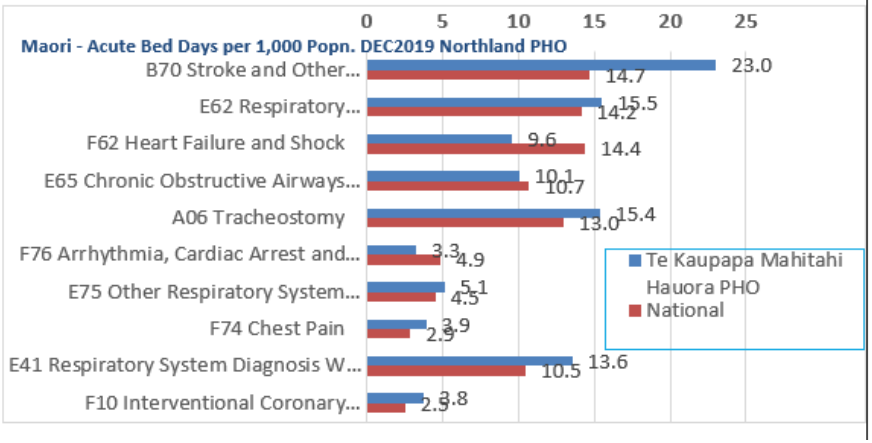
	Census Year	Age																				
		Total	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95-99	100+
Total population	2018	179,076	11,682	13,359	12,579	10,494	8,520	9,822	9,513	8,751	9,600	11,649	12,345	13,239	12,495	11,724	9,456	6,507	3,831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

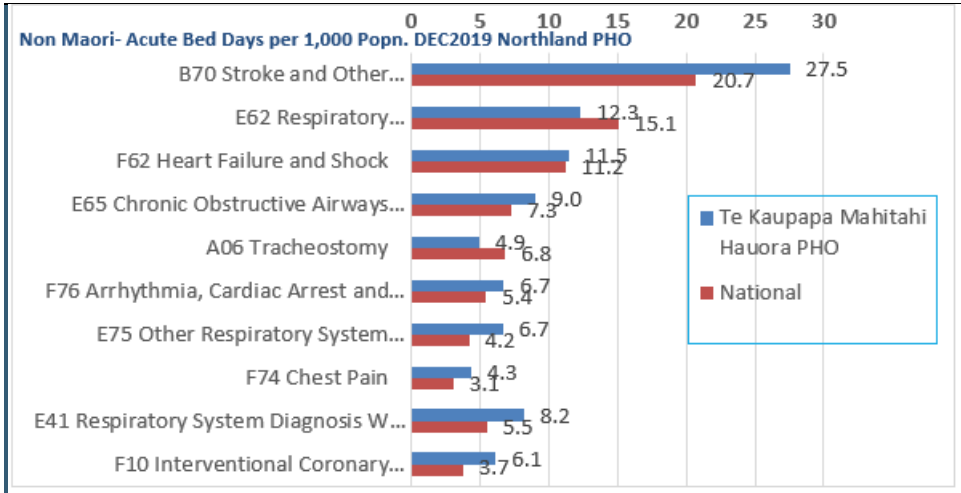
This data clearly demonstrates the impact of the growing population trends across Northland. Northland is also experiencing severe GP shortages which is resulting in more and more pressure on walk in services such as urgent care centres and ED centres. Managing the impact of Long-Term conditions, as well as identifying opportunities to improve patient flow throughout the system continues to a be a significant priority. There is significant evidence to suggest that providing shared care platforms through Multidisciplinary Teams (MDT) provides patients with the confidence to manage their condition at home , reducing the need for unplanned admission and presenting to urgent care facilities.at home, reducing the need for unplanned admission and presenting to urgent care facilities.

Source Dataset: Age and sex by ethnic group (grouped total responses), for census usually resident population counts, 2006, 2013, and 2018 Censuses (RC, TA, SA2, DHB)

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

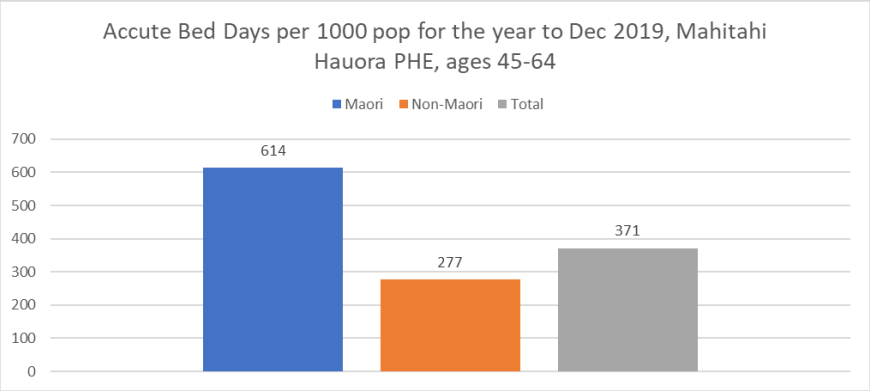


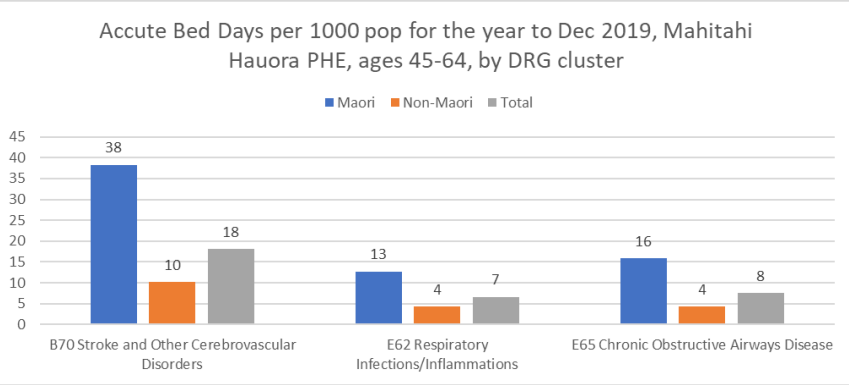




Data from https://nsfl.health.govt.nz/system/files/documents/pages/abd_pho_rpt_wdrgs_2019q4_v2.xlsb

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





Data from https://nsfl.health.govt.nz/system/files/documents/pages/abd_pho_rpt_wdrgs_2019q4_v2.xlsb

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

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

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

Milestones	Activities	Contributory measures
Improve the equity gap by 5% between Māori and non-Māori in the 45-64 age group – a reduction of 337 to 326 ABD per 1000 pop (Baseline2019)	Target patients with complex needs that are high users of secondary care and are amenable to primary care intervention: Coordination of individual packages of care by POADMS, focusing on respiratory, stroke and COPD, including active pull from wards for amenable early discharge. Develop and operationalise across sector approaches and activity that supports improved uptake of vaccination including Covid19 in Māori and Pacifica populations. Implement Multidisciplinary Team meetings to address complex management across cross sectoral health providers focused on improving management in primary care settings.	Acute bed days saved in respiratory conditions, Stroke and COPD Measure of number of patients with respiratory, Stroke or COPD accessing POADMS funding to either prevent hospital admission or decrease number of bed days Reduction in average LOS Māori Reduction in ASH rates Māori Reduction in ASH events Māori Influenza vaccination rate total eligible pop Influenza vaccination rate eligible population Māori and PI MDT meetings x 12 held by June 2022

Amenable Mortality SLM Plan for 2021/2022

Prevention and early detection

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

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

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

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

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

	2010	2011	2012	2013	2014	2015	2016 (provisional)
Diabetes	26	25	25	21	20	17	30
Valvular heart disease	7	10	7	5	10	9	9
Hypertensive diseases	3	5	4	3	2	7	3
Coronary disease	84	88	87	86	73	71	69
Heart failure	2	3	1	2	2	0	1
Cerebrovascular diseases	22	22	17	22	25	27	28
Pulmonary embolism	1	1	1	0	1	0	2
Atrial fibrillation and flutter	2	1	2	4	5	4	5
COPD	32	24	31	19	25	38	35

Approach to CVD.

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

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

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

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

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

In 2018/19 the Northland Alliance conducted a Point of Care testing pilot at AFFCO Moerewa, as part of SLM long term conditions CVRA screening, focused on HbA1c testing. The predominant ethnic group was Māori 64.9%. 56 (98.3%) of the participants completed questionnaires which were designed to assess their impressions and gain feedback about the study. The results showed 98.3% participants would recommend this programme to their family, whānau and work mates and 98.3% would participate if it was repeated in 2020. A paper has been published on the research from this project. It is with this learning in mind, alongside The Heart Foundation Māori men co-designed heart health work, that Mahitahi Hauora will implement Heart Health Hauora Ecosystem Popup Clinics.

Approach to Diabetes.

There are approximately 1,775 [6]people living with diabetes who are unknown to the Northland health system. Northland's Māori are significantly disproportionately affected by diabetes.[7]

Only 75.7% of northlanders living with diabetes have an hba1c recorded, 34.3% of Māori with diabetes have not got an hba1c recorded, compared to 14.6% non-Māori. there is a significant equity gap between Māori and non-Māori for patients with good control of 23%.[8]of the diabetic-related amputations in 2017/18, 44%[9] were undertaken on Māori.

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

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

- ensuring that the cardiovascular disease risk assessment for primary care guidelines are met and implemented
- that patients who have elevated risk for CVD are effectively prescribed triple and dual therapies on an equitable basis for Māori
- that patients who live with diabetes have appropriate support to live well with diabetes and manage their condition well in the community.

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

SS13 Improved management for long term conditions (Diabetes)

Numbers of people with diabetes

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

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

Numerator

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

Percentage rate based on total PHO/practice count rate

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

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

Milestones	Activities	Contributory measures
Reduce amenable mortality for Māori Men by 10% by June 2023	Work with primary care providers and whanau to provide education to priority populations focused on gout, heart disease and diabetes. Diabetes governance group to finalise the Northland diabetes strategy by end of Q1. Deliver diabetes strategy as part of diabetes education to all primary care providers across Northland by end of Q2. Develop LTC indicators clinical dashboard for general practice to increase easy tracking and identification of patients with diabetes and HbA1c <64, high CVRA risk and gout needing increased support. Support no or low-cost access to musculoskeletal (MSK) providers for eligible populations.	Number of education sessions provided Pharmaceutical dispensing of diabetes medication for Māori men with diabetes and prior CVD Pharmaceutical dispensing Dual/triple therapy for Māori men with prior CVD Number (and %) of Māori with HbA1c<64mmol/mol Number (and %) of Māori with known diabetes completing an annual Hba1c Number of eligible referrals to MSK program Number of eligible referrals to MSK Māori program

Locality scorecards: Māori men with known CVD and triple therapy

Measure	Sub-cat	Trend	Dec-20	Target	Change From the Last month	Change from July 2019	Jul-19
% of eligible population who have had a prior CVD event who are on triple therapy	Mahitahi Hauora		33%	50%	0%	9%	24%
% of eligible population who have had a prior CVD event who are on triple therapy for Māori men locality 3	Maori		37%	40%	2%	21%	16%

Scorecards: SLM amendable mortality ABD

Measure	Sub-Cat	Trend by month	Dec-20	Target	Change From the Last month	Change from July 2019	Jul-19
% of (CVDRA) done in 45-74 years for eligible population	Maori		86%		0.6%	-1%	87%
	Non-Maori		93%		0.2%	-2%	95%
% of (CVDRA) done in 30-44 years for eligible population	Maori		77%		1.2%	-4%	81%
% of people in 45-74 years Maori men who have high CVD risk (15+) and on dual and triple therapy (CVD management)	Maori		55%	60.0%	-0.2%	22%	33%
	Non-Maori		56%	60.0%	0.1%	16%	41%
% of people in 30-44 years Maori men who have high CVD risk (15+) and on dual and triple therapy (CVD management)	Maori		33%	50.0%	2.9%	17%	16%
% (Diabetes management 15-44 HbA1c < 64mmol	Maori		38%	50%	-1%	-6%	44%
	Non-Maori		48%	50%	-1%	-1%	48%
% (Diabetes management 45-74 HbA1c < 64mmol	Maori		56%	50%	0%	-5%	61%
	Non-Maori		67%	50%	0%	-7%	74%

Medicine Dispensing Rates by DHB of Domicile & PHO by Ethnicity. 12 months ended 30 September 2020

PHARMACEUTICALS DISPENSED BETWEEN 01 OCT 2019 AND 30 SEP 2020

	Key:	≤ 20.0%	≤ 30.0%	≤ 40.0%	> 40.0%	Key:	≤ 30.0%	≤ 40.0%	≤ 50.0%	> 50.0%	Key:	≤ 40.0%	≤ 50.0%	≤ 60.0%	> 60.0%
		CVDRA 15-20 On Dual					CVDRA >20 On Dual					Prior CVD On Triple			
		Maori	Pacific	Asian	Indian	Other	Maori	Pacific	Asian	Indian	Other	Maori	Pacific	Asian	Indian	Other
Northland	Te Kaupapa Mahitahi Hauora	21.6%	18.0%	24.2%	16.2%	21.8%	41.8%	38.2%	46.2%	36.7%	35.8%	49.9%	57.0%	45.2%	47.6%	48.2%

Source: PHO enrolments as at 01/10/2020 & CVDRA extracts to 30/09/2019

Patient Experience of Care SLM plan 2021/2022

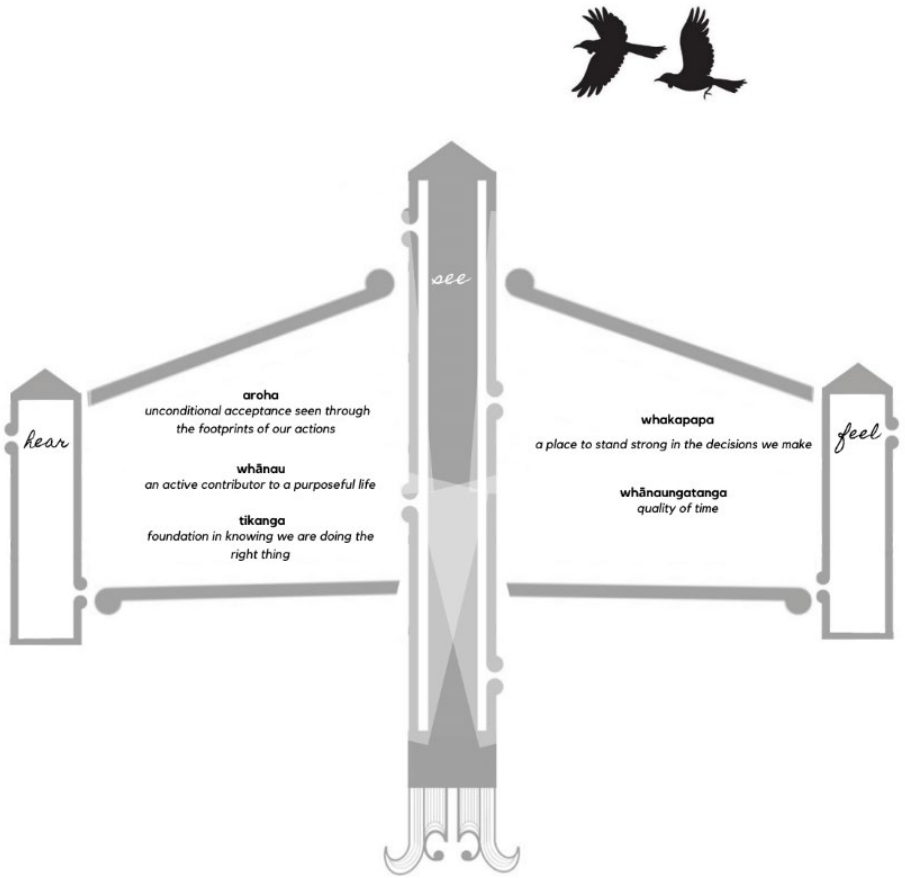
Improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care

This SLM is described as "patient experience of care using the [Health Quality and Safety] Commission's national adult hospital and primary care patient experience surveys".

Improvement milestone and activities for this SLM should focus on:

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

At its essence, the patient experience survey can inform planning, practices and clinicians of areas that they are performing well in and areas that require improvement. In a westernised world perspective, the models of engagement for surveys work relatively well however listening to the Māori community, we know that these methods are less effective at understanding their experience of care. Coupled with this, the infrastructure and delivery models for the surveys is predominantly via electronic collection.



what matters to whānau measurement papa tikanga

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

what matters to whānau tahā

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

Primary Care

System level outcome: delivering patient centred care.

Rationale:

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

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

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

Inpatient Survey

System level outcome: delivering patient centred care.

Rationale:

Patient experience as measured by the adult inpatient patient experience survey, administered by the Health Quality and Safety Commission, directly measures whether patients and their whānau are treated with respect and understanding. An improvement in this measure will see improved experiences for all patients including Māori across the domains covered by the surveys. Engagement and partnership is an obligation as a Treaty partner, and providing better support to people with high and complex needs via equitable public health services is a primary driver of effective healthcare.

Northland scores below the national average on the question 'Were you involved as much as you wanted to be in making decisions about your treatment and care?' Our goal is to improve the outcome by 2% over the next year and achieve an equitable outcome for Māori. Underpinning this improvement is a cultural shift towards improving the shared decision-making process between patients and clinicians, particularly for patients with co-morbidities and complex healthcare needs who are navigating treatment options. Increasing cultural competency in the hospital will benefit all patients at any age, as will improving serious illness capability as this can effect patients at any age.

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

Milestones	Activities	Contributory measures
Primary Care survey Reduce inequities in self-determined wellbeing by increasing the number of Māori who are involved in decisions regarding their own care by June 2022. (Baseline May 2021 Survey) Achieve at least 5% increase in positive responses from Māori patients to the survey questions • *In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it?* • *Did the GP or nurse involve you as much as you wanted to be in making decisions about your treatment and care?*	Work with practice staff to improve access to programmes that can empower self-determined wellbeing for Māori. • Improvement partners are to encourage practices to meet their Kia Ora Vision enrolment and the newly refreshed Shared Care Plan tool Whānau Tahi, Patient Centred Care Plan targets for Māori patients with long term conditions: • identifying enrolled Māori without current or up-to-date care plans using risk stratification tools. • meeting with practices to create an action plan to improve, including working with the wider workforce (e.g. HIPs) and other providers (e.g., iwi and Māori providers). Assist general practice to interpret and use the PE Survey results and promote positive communications about it : • highlighting the importance of the survey at monthly practice manager's meetings • seeking ideas on how they will work with their staff, or what support they require. Improvement Partners to discuss with practice staff prior to quarterly surveys.	2% Increase in Māori who have a Whanau Tahi Shared Care Plan (from 5,219) 5% Increase in Māori patients who have an up-to-date Care Plan (from 2,355) Achieve at least 5% increase in positive responses from all patients to the following survey question: • *Do you have a shared treatment or care plan agreed with a healthcare professional to manage your condition(s)?*"
Inpatient survey A 2 % improvement on the question 'Were you involved as much as you wanted to be in making decisions about your treatment and care?' by 30 June 2022	Co-design a national communication guideline to enable clinicians to have meaningful conversations with patients on changes to the End of Life Choices Act, in partnership with HQSC and consumers. Promote the change in legislation across the hospital and establish a working group. Increase the number of Serious Illness Conversation facilitators by 50% by June 2022.	The number of attendees to 'Serious Illness Conversation' workshops over the next year. The number staff attending Māori cultural competency workshops. Complete audit of current resuscitation documentation by October 2021 Complete an audit of the revised Care Plan by January 2022 to identify areas for improvement

Milestones	Activities	Contributory measures
	Rollout a revised Care Plan document that is designed to be completed in partnership with the patient based on goals – on “what Matters to them.” Implement the rollout of a revised treatment plan form to be used in all departments (based on HQSC Shared Goals of Care project) by June 2022. Establish a Shared Goals of Care Governance group and establish a baseline of current practice in documenting resuscitation discussions with patients.	

Youth Health SLM Plan for 2021/2022

Youth are healthy, safe and supported

Mahitahi Hauora lead the Youth Health SLM for Northland

The SLM will carry over from 2020-2021 and focuses on Mental health and Wellbeing – Self harm hospitalisations and short stay ED presentations.

Annual Service Plan 2020-2022

Young people experience less mental distress and disorder and are supported in times of need as measured by Self-harm hospitalisations and short stay ED presentations for <24year olds.

Background

Through the appreciative inquiry process undertaken in the Whakapiki ake Taitamariki locality (identified by youth across Bream Bay, Onerahi, Raumanga and Dargaville) taitamariki, services and communities expressing the need to work at three key priorities:

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

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

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

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

Thus, we have selected the Mental Health and Wellbeing domain to measure the impact of our plan.

Two significant events have occurred over the 2020-2021 year to which both profoundly positive and negative impacts have, and continue to occur, which are yet to determine the measures for this work;

1. Firstly - COVID 19 seriously impacted the flow of both access for individuals and whanau to services as well as response from services back to whanau was also disrupted by the lockdown. As a result of this both locality services and the ministry responded with assessments and evaluation of experience to understand

impact followed by quick applications to remedy improved access. Innovation to improve access to service has yet to be seen. The benefit of these efforts are anticipated in coming months.

Rapid Evidence and Policy Brief: COVID19 Youth Recovery Plan 2020-2022

https://www.hpa.org.nz/research-library/research-publications/rapid-evidence-and-policy-brief-covid-19-youth-recovery-plan-2020-2022

The following themes were identified in the Youthline Survey on the negative aspects of COVID-19 and are detailed below: Page 11

- *Young people are facing financial instability and employment insecurity*
- *Young people are craving a return to normalcy in education*
- *Young people are missing physical connection*
- *Young people are feeling distressed*
- *Young people are concerned about living in toxic environments*
- *Young people are concerned about family violence*
- *Young people are expressing concerns about accessibility and others' wellbeing*

COVID 19 Kia Kaha, Kia Maia, Kia ora Aotearoa – Psychosocial and Mental Wellbeing Recovery Plan

https://www.health.govt.nz/system/files/documents/publications/covid-19-psychosocial-mental-wellbeing-recovery-plan-15may2020.pdf

Children and young people are at risk of longer-term impacts- Mental distress and substance related harm in adult life is largely an outcome of child and adolescent mental health exposures. It is important to actively protect children and young people from the flow-on impacts of parents/caregivers/ whanau wellbeing, as well as prevent intergenerational transmission of negative impacts in the future.

2. Secondly- Te Rau Ora, who is the lead agency to improve Māori Health and indigenous wellbeing, via health workforces, introduced in September a Self-harm and Suicide Prevention strategy nationally which has released significant financial resource and collaboration impetus into the community, forging and strengthening SLM work in the community. It would be significant in this second year to locate groups and services participating in this project to link efforts and activities compounding expertise, benefits, within communities and formal service delivery systems.

Annual Plan Objectives formulated for the current and coming year ending June 2022

1. Youth workers to provide facilitation and connection to health and social services as well as regular activities such as sports, arts as designed by taitamariki.
2. Improve 'youth appropriate access' enabling successful navigation and participation in the community to achieve life's transitions.
3. Increase access to interventions that build whanau and community resilience to self-manage
4. Increase the quality of care through expanded practice of Specialist Youth Health roles
5. Improve access to health social services for Taitamariki across Northland – schools and community to address wider determinants of health and wellbeing.

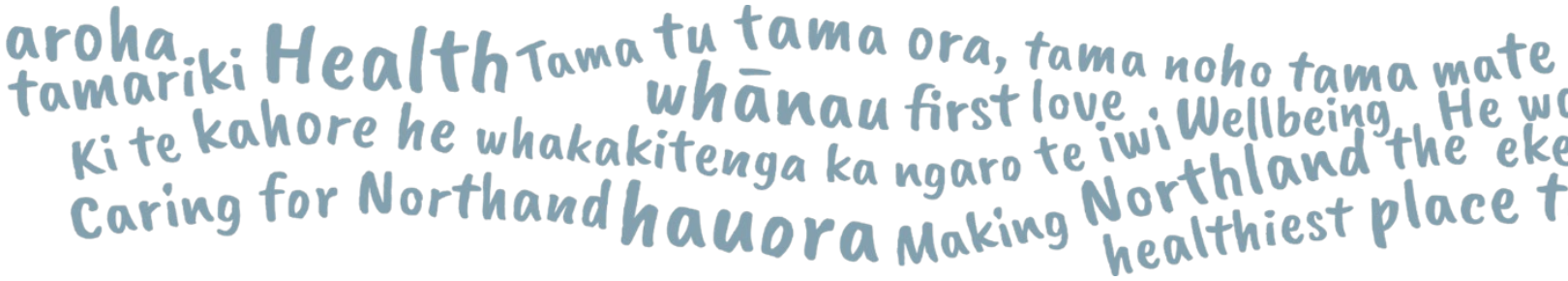
Our data set will be the PHO level data for the specific age group of 20 to 24year olds, which as at end of Sept 2020:

- The data shows the total number of self-harm hospitalisations among young people aged 10-24

- **Reference: Nationwide Service Framework Library:** https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/youth-slm-6
- Clarification and detail of the specifications of admissions is included in the reference material attached. https://nsfl.health.govt.nz/system/files/documents/pages/self_harm_hospitalisations_technical_document_v1_1.docx

Service involvement- included:

- Whakapiki ake Taitamariki
- Northland Youth Health services – School-based health services
- NDHB – Te Roopu Kimiora, Adult Mental Health services
- Iwi Māori Providers- Te Kahu o Taonui / Ngati Hine / Te Hiku/ Kia A ora Ngatiwai / Te Ha Oranga /
- Primary Health organisations: THOON/ Hauora Hokianga
- Rubicon
- Oranga Tamariki
- NGO services



Report Data for this Plan: Report for patient PHOs, September 2020

PHO Analysis; Age Group Analysis; Ethnic Analysis; Gender Analysis; Deprivation Analysis

Age Group Analysis:

Self Harm Hospitalisations - Total <= Select Self Harm Hospitalisation Classification | Total <= Select Gender | Total <= Select Ethnic Group | Total <= Select Deprivation Quintile

Report for Patient PHOs, September 2020

Age Group Comparison - Age-specific Youth Self Harm Hospitalisation Rates (per 10,000 population)

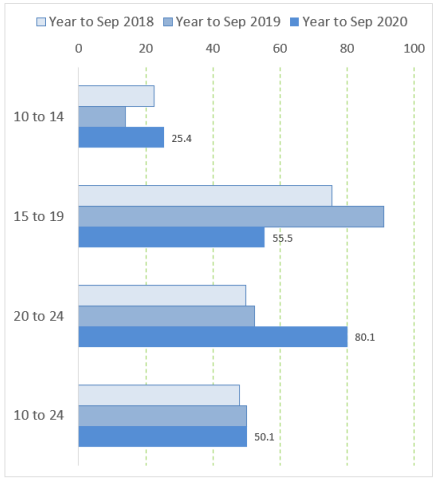
Te Kaupapa Mahitahi Hauora

Age Group	Population Year to Sep 2020	Number of Self Harm Hospitalisations - Total Year to Sep 2020	Age-specific Self Harm Hospitalisation Rates (per 10,000 population) Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
10 to 14	12,599	32	22.6	13.8	25.4
15 to 19	10,444	58	75.4	91.1	55.5
20 to 24	8,489	68	49.8	52.5	80.1
10 to 24	31,532	158	47.8	50.0	50.1

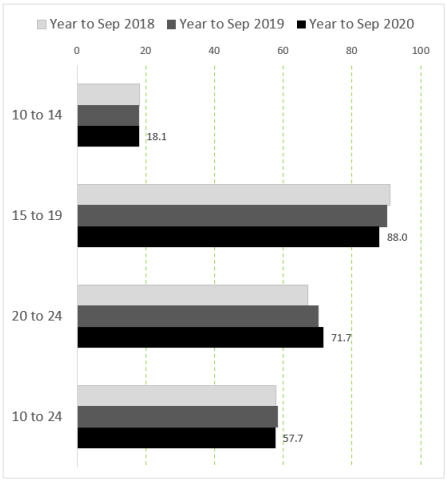
National

Age Group	Population Year to Sep 2020	Number of Self Harm Hospitalisations - Total Year to Sep 2020	Age-specific Self Harm Hospitalisation Rates Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
10 to 14	321,251	580	18.2	18.1	18.1
15 to 19	288,358	2,538	91.2	90.2	88.0
20 to 24	286,007	2,052	67.2	70.3	71.7
10 to 24	895,616	5,170	58.0	58.3	57.7

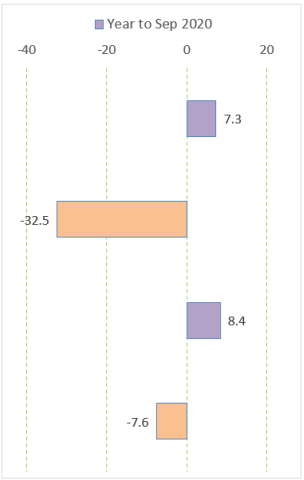
Te Kaupapa Mahitahi Hauora



National



Difference Between PHO and NZ Rates



Ethnic Group Analysis:

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

10 to 24 <= Select Age Group

Total <= Select Gender

Total <= Select Deprivation Quintile

Report for Patient PHOs, September 2020

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

Using Standard Population: Census 2013 Usual Resident Population

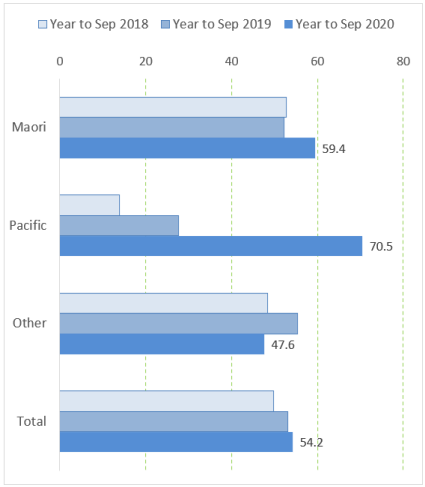
Te Kaupapa Mahitahi Hauora

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Ethnicity	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020	Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
Maori	16,195	87	53.7	52.8	52.2	59.4
Pacific	772	6	77.7	13.9	27.7	70.5
Other	14,565	65	44.6	48.3	55.3	47.6
Total	31,532	158	50.1	49.7	53.2	54.2

Please note that 'Other' category on this report shows the results for people who are not Māori and not Pacific.

Age Standardised Youth Self Harm Hospitalisation Rates

Te Kaupapa Mahitahi Hauora



Gender Analysis:

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

10 to 24 <= Select Age Group

Total <= Select Ethnic Group

Total <= Select Deprivation Quintile

Report for Patient PHOs, September 2020

Gender Comparison - Youth Self Harm Hospitalisation Rates (per 10,000 population)

Using Standard Population: Census 2013 Usual Resident Population

Te Kaupapa Mahitahi Hauora

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Gender	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020	Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
Male	15,982	39	24.4	25.3	32.7	28.4
Female	15,550	119	76.5	74.7	74.2	80.5
Total	31,532	158	50.1	49.7	53.2	54.2

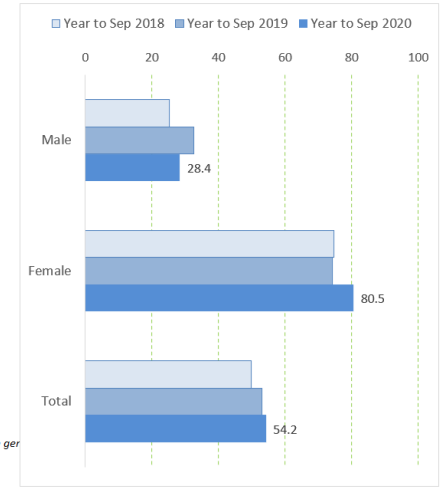
National

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Gender	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020	Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
Male	450,173	1,306	29.0	30.9	32.2	30.8
Female	445,443	3,862	86.7	88.3	88.3	89.3
Total	895,616	5,170	57.7	59.6	60.2	60.0

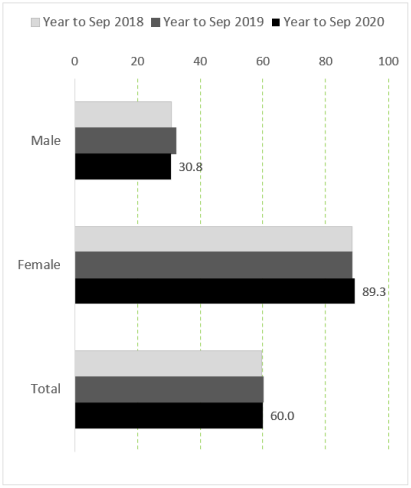
** Reported number of self harm hospitalisations does not include 2 hospitalisation(s) from people with other or unknown ger*

Age Standardised Youth Self Harm Hospitalisation Rates

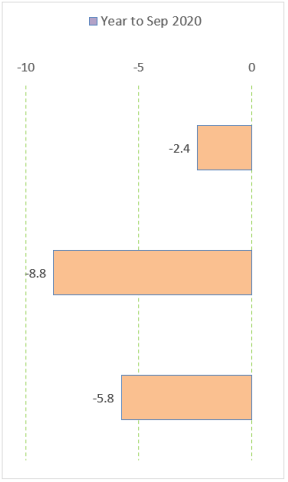
Te Kaupapa Mahitahi Hauora



National



Difference Between PHO and NZ Rates



Deprivation Quintile Analysis:

Self Harm Hospitalisations - Total <= Select Self Harm Hospitalisation Classification | 10 to 24 <= Select Age Group | Total <= Select Gender | Total <= Select Ethnic Group

Report for Patient PHOs, September 2020

Deprivation Quintile Comparison - Youth Self Harm Hospitalisation Rates (per 10,000 population)

Using Standard Population: Census 2013 Usual Resident Population

Te Kaupapa Mahitahi Hauora

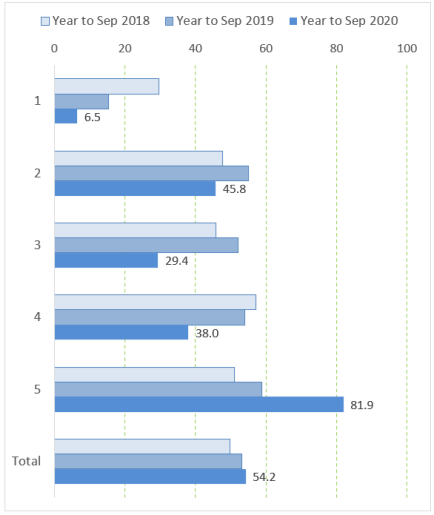
	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Dep Quintile	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020	Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
1	2,362	2	8.5	29.6	15.3	6.5
2	3,647	15	41.1	47.6	55.0	45.8
3	5,174	15	29.0	45.8	52.2	29.4
4	7,100	26	36.6	57.1	54.1	38.0
5	13,248	100	75.5	51.1	58.8	81.9
Total	31,532	158	50.1	49.7	53.2	54.2

National

	Population	Number of Self Harm Hospitalisations - Total	Actual Self Harm Hospitalisation Rate (per 10,000 popn)	Age Standardised Self Harm Hospitalisation Rate (per 10,000 population)		
Dep Quintile	Year to Sep 2020	Year to Sep 2020	Year to Sep 2020	Year to Sep 2018	Year to Sep 2019	Year to Sep 2020
1	194,066	782	40.3	45.0	39.9	42.5
2	168,338	784	46.6	49.2	51.9	48.9
3	161,183	902	56.0	57.7	59.7	58.2
4	167,356	1,245	74.4	76.4	77.0	76.0
5	204,674	1,457	71.2	69.7	72.6	73.3
Total	895,616	5,170	57.7	59.6	60.2	60.0

Age Standardised Youth Self Harm Hospitalisation Rates

Te Kaupapa Mahitahi Hauora



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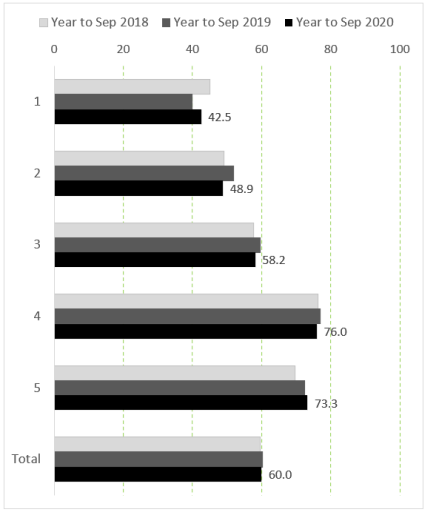
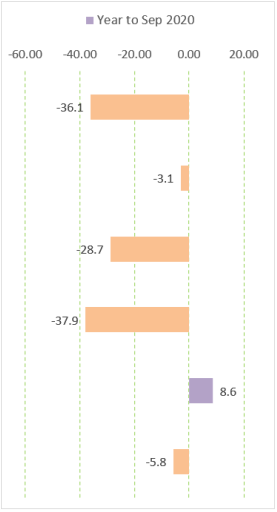


Difference Between PHO and NZ Rates



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

Milestones	Activities	Contributory measures
5% reduction in Age Standardised youth self - harm hospitalisation rates by 30 June 2022.	1. Workforce training –MH Credential for all those working with youth, evidence-based and equity focused. 2. Workforce training – MH:101 2.1 Set up and circulate calendar of training events Employ and follow up with Induction training 5 youth workers 2.2 Complete recruitment of Youth Workers following RFP process 2.3 Implement He Kakano Ahau – Youth wide 3. All Youth and PMH workers report monthly on incidence of Self Harm 4. Trial 12 x Community Care Management (CCM)/Multidisciplinary Team Meetings (MDT) 5. Taitamariki engaged with youth and PMH workers have pre- and post-depression and anxiety screening scores 5.1 Implement roll out of Tiheiwa Mauri Ora – assessment resource 5.2 Evaluate effectiveness 6. Taitamariki engaged with youth and PMH workers have Care plans **Additional tasks 2021-2022** 7. COVID-19 7.1 Review PMH model of care 7.2 Redesign model of care incorporating Youth Health worker 8. Te Rau Ora – Project innovation 8.1 Identify all Te Rau Ora participants 8.2 Create a Northland wide forum for shared innovation 8.3 Identify number of hui achieved over the project period – Sept 2020 – March 2021 8.4 Identify number of initiatives set to progress in the coming year – July2021- June 2022	**Contributory measures continue July 2021-June 2022** Number of workers trained MH Credential Number of workers trained MH:101 / Health literacy Induction training completed for all new Youth workers Monthly reporting demonstrates trends of Self Harm and promotion/ prevention activities Report monthly CCM/MDT meeting Increase number of referrals of vulnerable youth to primary mental health services 80% Taitamariki engaging primary mental health support show an improvement in post screening scores (e.g. Kessler 10) 80% Taitamariki complete Care Plans developed through Community Care.

Babies Living in Smoke Free Homes SLM Plan for 2021/2022

A healthy start

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

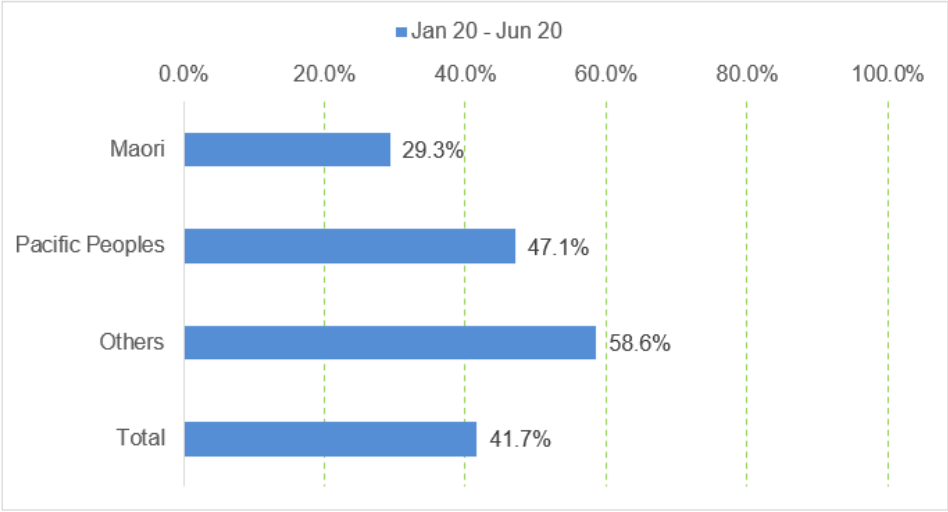
As at June 2020, the latest data available, only 29.3% of Māori babies are living in smokefree homes compared to 58.6% for non-Māori, non-Pacific – an equity gap of just under 30%. The data for Northland is also worse than the national average, Māori babies living in smokefree homes nationally is 33.5% and for non-Māori non-Pacific it is 65.6%.

Ethnic Group Data - Babies living in smokefree homes at 6 weeks post natal

Northland DHB of Domicile

	Num	Denom	Rate of Smokefree Homes
Year	Jan 20 - Jun 20	Jan 20 - Jun 20	Jan 20 - Jun 20
Maori	201	686	29.3%
Pacific Peoples	16	34	47.1%
Others	292	498	58.6%
Total	509	1,222	41.7%

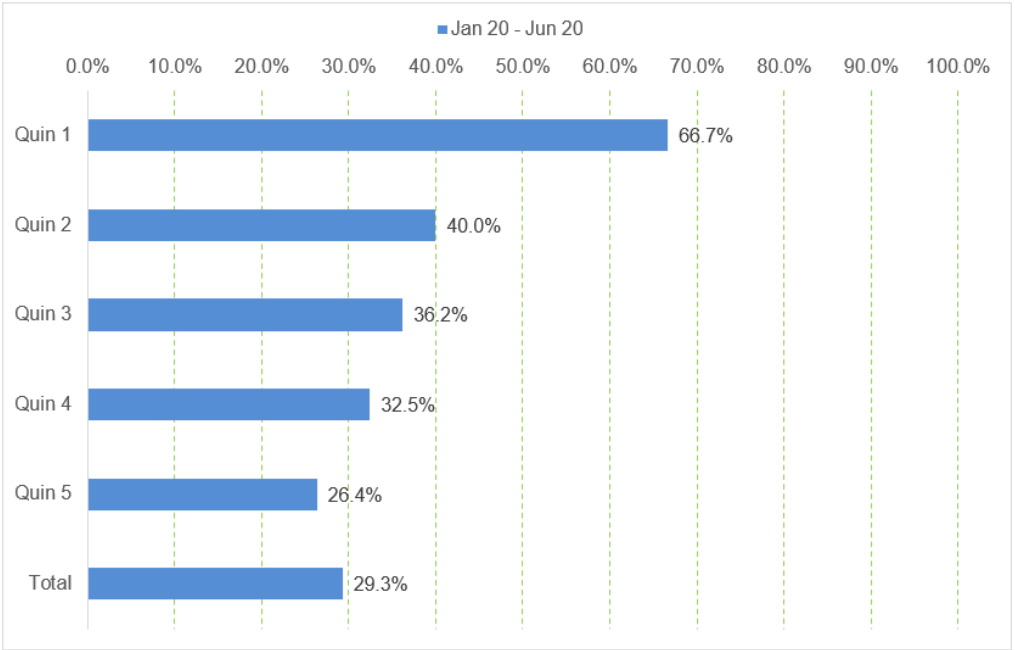
Northland DHB of Domicile



When the data is analysed by ethnicity and quintile an even greater picture of inequity is revealed.

Selections For Deprivation Quintile Analysis: Northland <= Select DHB | Maori <= Select Ethnic Group | Total <= Select Gender

Dep Quintile	Num Jan 20 - Jun 20	Denom Jan 20 - Jun 20	Rate of Smokefree Homes Jan 20 - Jun 20
Quin 1	2	3	66.7%
Quin 2	12	30	40.0%
Quin 3	21	58	36.2%
Quin 4	49	151	32.5%
Quin 5	117	444	26.4%
Total	201	686	29.3%



Significant additional effort, over and above current service delivery, is required to prioritise and support Māori to stop smoking, with a significant push to support hapū mama to quit. The Support to Stop Smoking model is being changed from a quantity based, to a quality focused service, to incentivise Wahine Māori and Hapu Mama, to quit smoking. This will be measured by number of those presenting and taking this up with G.P's, as well as number of referrals by G.Ps to Toki Rau.

Data source - https://nsfl.health.govt.nz/system/files/documents/pages/slm_blsh_jan_jun_2020.xlsm

Government theme: Improving the well-being of New Zealanders and their families

System outcome:	Government priority outcome:
We have health equity for Māori and other groups	Make New Zealand the best place in the world to be a child

Milestones	Activities	Contributory measures
Rate of smokefree homes for Māori pēpi has increased from 29.3% at June 2020 to 35% at June 2022.	Review and refine the 'support to stop smoking service' within general practice to retain the focus on hapū wāhine and wāhine Māori. Continue to encourage referrals from general practices to Toki Rau.	Number and % Māori wāhine enrolled in stop smoking service Number and % Māori wāhine who complete programme who stop smoking Number of referrals from General Practice to Toki Rau.
	Review BLISH data at quarterly clinical meetings with Well Child / Tamariki Ora providers and discuss importance of data collection. Provide training to Well Child / Tamariki Ora providers on stop smoking support. Utilising the Smokefree Kaitiaiki role support to LMCs and Well Child / Tamariki Ora providers to increase the number of quality referrals for their clients to quit smoking services.	Increase number of quality referrals of Māori to Toki Rau Stop Smoking Services
	Deliver four hapū mama and whanau wellbeing wananga "Whaia Te Ora" – focus on wellbeing with the overall goal of whanau working towards a quit smoking decision. Based on the Māori creation narrative following the same journey as Hine Kōpū. Referrals to Whaia Te Ora will predominately be via Hine Kōpū with other options being explored from secondary care.	Number of referrals for hapū mama and whanau to Toki Rau following attendance at Whaia te Ora
	Develop a business case to fund dedicated stop smoking support for hapū māmā and wāhine Māori; approach NDHB and Mahitahi Hauora for funding once business case developed.	Business case developed Funding received Project implemented Increased numbers of hapū māmā quit
	Utilise social media e.g., Toki Rau Facebook page and website to generate referrals for hapū māmā and wāhine Māori.	Number of referrals to Toki Rau for hapū māmā and wāhine Māori

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Ki te kahore he whakakitenga ka ngaro te iwi
Caring for Northand hauora Making Northland the ek
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aroha
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whānau first love
Ki te kahore he whakakitenga ka ngaro te iwi Wellbeing He waka
Caring for Northand hauora Making Northland the eke noa
healthiest place to live

Appendix 3 Accounting Policy 2020/21

Reporting entity

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

The consolidated financial statements of Northland DHB and group for the year ended 30 June 2020 comprise Northland DHB, its controlled entity the Kaipara Total Health Care Joint Venture (54% owned) and its jointly controlled entities healthAlliance N.Z. Limited (25% owned) and HealthSource New Zealand Limited (10% owned).

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

The financial statements were authorised for issue by the Board on 30 October 2020.

Basis of preparation

Statement of compliance

The financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZGAAP).

The financial statements comply with PBE and other applicable Financial Reporting Standards, as appropriate for public benefit entities. They have been prepared in accordance with Tier 1 PBE Accounting Standards and are on a going-concern basis.

Going Concern

The Board has considered the circumstances which could affect the validity of the going concern assumption, including its responsibility to settle the estimated historical Holidays Act 2003 liability. There is uncertainty whether Northland DHB will be able to settle this liability, if it becomes due within one year from approving the financial statements. To support the Board's going concern assumption, a letter of comfort was obtained from the Ministers of Health and Finance. The letter outlines that the Crown is committed to working with Northland DHB over the medium term to maintain its financial viability. The Crown acknowledges that equity support may need to be provided, where necessary, to maintain viability.

Presentation currency

The financial statements are presented in New Zealand Dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the Northland DHB and its subsidiary is New Zealand dollars (NZ$).

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE accounting standards requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, revenue and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgments about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates will be recognised in the period in which the estimate is revised if the revision

affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

Land and buildings revaluations

Note 10 provides information about the estimates and assumptions applied in the measurement of revalued land and buildings.

Long service leave, retirement gratuities and Holidays Act 2003 liability

Note 15 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities, as well as leave entitlements under the Holidays Act 2003.

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

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

Critical judgments in applying accounting policies

Leases classification

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

Judgment is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

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

Changes in accounting policies

Goods and Services tax

The DHB has changed the accounting treatment of net GST paid to and received from the IRD in the statement of cash flows. Previously these cash flows were disclosed separately within operating cash flows. The cash flows are now amalgamated with cash paid to suppliers, within operating cash flows. The reasons for the change are for consistent treatment of GST between the statement of cash flows and the statement of financial position and budgeted GST cash flows. The amount of net GST paid to the IRD for the year ended 30 June 2020 was $ 416k (2019: $381k refunded).

Intangible assets – Finance procurement and Information Management System (FPIM)

The DHB has changed the accounting treatment for the recognition and subsequent measurement of the FPIM investment. The DHB previously accounted for the investment as an indefinite life intangible asset.

Further to a recent accounting opinion obtained by NZHPL, the DHB will use a combination of accounting treatments to account for this investment. The new treatment of this investment is disclosed in the intangible assets accounting policy.

Interests in other entities

In January 2017, the XRB issued new standards for interests in other entities (PBE IPSAS 34-38). These new standards replace the existing standards for interests in other entities (PBE IPSAS 6-8). The new standards were effective for annual periods beginning on or after 1 January 2019, with early adoption permitted.

The DHB has applied these new standards in preparing the 30 June 2020 financial statements. Adoption of these new standards has had no impact on the financial statements.

Standards early adopted

There have been no standards early adopted during the financial year.

Standards issued and not yet effective and not early adopted

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

Amendment to PBE IPSAS 2 Statement of Cash Flows

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

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes most of PBE IPSAS 29 Financial Instruments: Recognition and Measurement and PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022.

The main changes compared to PBE IPSAS 29 that are relevant to the DHB are:

-New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.

-A new impairment model for financial assets based on expected losses, which might result in the earlier recognition of impairment losses.

The DHB intends to adopt PBE IPSAS 41 for the 30 June 2023 financial year.

Although Northland DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

PBE FRS 48 Service Performance Reporting

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

Basis for consolidation

Subsidiaries

Subsidiaries are entities controlled by Northland DHB. Control exists when Northland DHB is exposed, or has rights to, variable benefits (either financial or non-financial) and has the ability to affect the nature and amount of those benefits from its power over the entity. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

The consolidated financial statements include the parent (Northland DHB) and its subsidiary. The subsidiary is accounted for using the acquisition method, which involves adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or revenue and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements.

Investments in subsidiaries are carried at cost in Northland DHB's own "parent entity" financial statements.

Investments in Joint Ventures

Joint Ventures are those entities over whose activities Northland DHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Joint Ventures are not accounted for using the equity method as they are not material.

Investments in Joint Ventures are carried at cost in Northland DHB's own parent entity and group financial statements.

Budget figures

The group budget figures presented in the financial statements comprise of the Northland DHB parent figures that were approved in its statement of performance expectations and the subsidiary's budget figures that were approved by its own board. The budget figures have been prepared in accordance with GAAP using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Foreign currency transactions

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

Cash and cash equivalents

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

Trade and other receivables

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

Northland DHB bases the measurement of expected credit losses on forward-looking information, as well as current and historic information. They have been grouped based on the days past due.

Short term receivables are written off when there is no reasonable expectation of recovery.

Trade and other payables

Trade and other payables are recorded at their face value.

Investments

Bank term deposits

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

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

Inventories

Inventories held for distribution in the provision of services that are not supplied on a commercial basis are measured at cost (using the average weighted cost method) and adjusted when applicable, for any loss of service potential.

Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

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

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

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

Interest bearing borrowings

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

Property, plant and equipment

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

Owned assets

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

Revaluations

Land and buildings are revalued to fair value as determined by an independent registered valuer at least every three years or, where there is evidence of a significant change in fair value. The net revaluation results are credited or debited to other comprehensive revenue and is accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue but is recognised in the surplus or deficit.

Any subsequent increase on revaluation that offsets a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue.

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

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

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

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

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the surplus or deficit is calculated as the difference between the net sales price and the carrying amount of the asset. The gain or loss is recognised in the reported net surplus or deficit in the period in which the

transaction occurs. Any balance attributable to the disposed asset in the asset revaluation reserve is transferred to retained earnings.

Additions to property, plant and equipment

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

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

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred, if it is probable that the service potential or future economic benefits embodied within the new item will flow to Northland DHB. All other costs are recognised in the statement of comprehensive revenue as an expense as incurred. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided using the straight line method on all property plant and equipment other than land, and recognised in the surplus or deficit.

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

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

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

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

Borrowing costs

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

Intangible Assets

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

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

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

Subsequent expenditure

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

Finance, Procurement and Information Management System (FPIM)

The Finance, Procurement and Information Management System (FPIM) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide

benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme.

Northland DHB holds:

- an intangible asset for the cost of capital invested by Northland DHB in the FPIM application. This is is reviewed for impairment at each balance date;
- an intangible asset for the cost of capital invested by Northland DHB in the FPIM central implementation costs. This will be amortised over 15 years when the asset is brought into use in October 2020 (as at 30 June these costs paid to date are recognised as a prepayment); and
- a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over a five year period from October 2020.

Amortisation

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

Class of asset	Estimated life	Amortisation rate
Software	2 to 3 years	(33% - 50%)
FPIM	14 to 15 years	(6% - 7%)

Impairment of property, plant and equipment and intangible assets

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

Intangible assets that have an indefinite useful life, or not yet available for use, are not subject to amortisation and are tested annually for impairment.

Assets that have a finite useful life are reviewed for indicators of impairment at each balance date. When there is an indicator of impairment the asset's recoverable amount is estimated. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the fair value of an asset cannot be reliably determined by reference to market based evidence. Specialised Hospital Buildings are an example of this.

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

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

Employee benefits

Defined contribution schemes

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

Defined benefit schemes

Northland DHB makes employer contributions to the Defined Benefits Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Short-term employee entitlements

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

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

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

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows.

Presentation of employee entitlements

Sick leave, continuing medical education leave, annual leave, long service leave that is available for use, and sabbatical leave that is available for use are classified as a current liability. Long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are also classified as a current liability. All other employee entitlements are classified as a non-current liability.

Bonuses

A liability and an expense are recognised for bonuses where there is a contractual obligation or where

there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Provisions

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

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring

has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Accredited Employers Programme

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

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

The liability for the ACC Accredited Employers Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

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

The components of equity are Retained Earnings, Revaluation Reserve (consisting of Land and Buildings), non-controlling interest in the group and Trust/Special Funds. The minority interest in the group is represented by the joint venture partner in the controlled entity.

Trust/Special Funds

Trust/Special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from revenue earnings to trust funds.

Property revaluation reserve

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

Fair value through other comprehensive revenue and expense reserves.

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

Revenue

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

Ministry of Health population-based revenue

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

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

Ministry of Health Contract Revenue

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Northland DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Goods sold and services rendered

Revenue from goods sold is recognised when Northland DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Northland DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

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

Revenue from other DHBs

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

Donated services

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

ACC contract revenue

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

Rental revenue

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

Interest

Interest revenue is recognised using the effective interest method.

Expenses

Operating leases

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

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

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where Northland DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Financing costs

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

Capital charge

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

Contingent liabilities

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

Cost of service (Statement of Performance)

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of Northland DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost allocation

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

Cost allocation policy

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

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

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

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

Income tax

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

Goods and services tax

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

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

Commitments and contingencies are disclosed exclusive of GST.